

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17413

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> c. LENGTH OF STAY IN 1b <u>2 mos 8 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hyattsville Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>401 Mich. Ave N.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>(Rev.) Edward Philip Arbez</u> First Middle Last			4. DATE OF DEATH <u>12 27 1967</u> Month Day Year				
5. SEX <u>m</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED WIDOWED <input type="checkbox"/> EVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-16-1881</u> 86 yrs.	9. AGE (In years lost birthday) <u>86</u>	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRIST (CATHOLIC) Retired Priest</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Priest</u>		11. BIRTHPLACE (County & State, or foreign country) <u>FRANCE</u>		
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>UNKNOWN</u>				
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				
16. SOCIAL SECURITY NO. <u> </u>			17. INFORMANT <u>THEOLOGICAL COLLEGE RECORDS</u> Address <u>SAME AS #2</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 years</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 10, 1964</u> to <u>Dec 27, 1967</u> , that (I) (we) last saw the deceased alive on <u>Dec 25, 1967</u> , and that death occurred at <u>2:30 PM</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>Thomas F Collins</u>			22b. DATE SIGNED <u>DEC 29 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>322-H at N.E.</u>		
22d. ADDRESS <u>322-H at N.E.</u>			23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				
23b. DATE THEREOF <u>12-30-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St Charles College Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltonville Maryland</u>	24. FUNERAL DIRECTOR <u>Francis Collins 3821-1472 St. NW Wash. D.C.</u>				
25a. REC'D BY REGISTRAR DATE <u>DEC 29 1967</u>			25b. REGISTRAR'S SIGNATURE <u> </u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11011

ESTABLISHED 1881

1881

1881



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>75 min.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cedar Heights</u>		d. STREET ADDRESS <u>914 65th. Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lonnie</u> Middle <u>L</u> Last <u>Bailey</u>		4. DATE OF DEATH Month <u>12</u> Day <u>3</u> Year <u>19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-11-1948</u>
9. AGE (In years last birthday) <u>19</u> yrs.		IF UNDER 1 YEAR Months <u>16</u> Days <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Porter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GARAGE</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D. C</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Artemus Bailey</u>		14. MOTHER'S MAIDEN NAME <u>Lillian McGoinis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Lillian Bailey</u>		Address <u>Same as 2 D</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal failure</u> <u>7054</u> DUE TO <u>Glomerulonephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>From Lupus erythematosus</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.		22. DATE SIGNED <u>12-4-67</u>	
EXAMINER'S NAME (Type) <u>John Kehoe, M.D.</u> <u>Riverdale, Md.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-7-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Harmony</u>	23d. LOCATION (City or Town) (County) (State) <u>Highland Park Md</u>
24. FUNERAL DIRECTOR <u>H. S. Washington Sons</u> ADDRESS <u>4925 Deane Ave</u>		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
DATE <u>DEC 11 1967</u>			

4205

10-10-1970

2157

10-10-1970

10-10-1970

10-10-1970

10-10-1970

10-10-1970

10-10-1970

10-10-1970

10-10-1970

10-10-1970

10-10-1970

10-10-1970

10-10-1970

10-10-1970

10-10-1970

10-10-1970

10-10-1970

10-10-1970

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
17413
17416
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN It 2 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 6034 Telegraph Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Andrew Middle P. Last Baldwin		4. DATE OF DEATH Month Dec. Day 5 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 31 Dec 1883
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 1 Days 8 Hours 3 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plant Manager		10b. KIND OF BUSINESS OR INDUSTRY D.C. Government	
11. BIRTHPLACE (County & State, or foreign country) Prince George, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gabriel Baldwin		14. MOTHER'S MAIDEN NAME Sarah V. Cook	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Robert F. Baldwin		Address Same as #2 (son)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis (myocardial infarction) DUE TO 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardio-renal disease DUE TO Diabetes Mellitus (c) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Nephrosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Dec 2 , 19 67 , to Dec. 5 , 19 67 , that (I) (we) last saw the deceased alive on Dec. 5 , 19 67 , and that death occurred at 2:15 AM , from causes and on the date stated above.			
22a. SIGNATURE George Hageage		22b. DATE SIGNED 12-5-67	
22c. PHYSICIAN'S NAME (Type) George Hageage, M. D.		22d. ADDRESS 3717 38th Ave., Cottage City, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/8/67	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City or Town) (County) (State) Suitland P.G. Md.	
24. FUNERAL DIRECTOR Francis Gasch's Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR DEC 11 1967		25b. REGISTRAR'S SIGNATURE Francis Judge	

1013

1013

1013

1013

1013

1013

1013

1013

1013

1013

1013

1013

1013

1013

1013

1013

1013

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
c. LENGTH OF STAY IN 1b DOA		d. STREET ADDRESS 3817 58th. Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Wendell Middle Fields Last Barker		4. DATE OF DEATH Month 12 Day 15 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 May 1892
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 12 Days 15 Hours 19 Min. 67	11. IF UNDER 24 HRS. Months 12 Days 15 Hours 19 Min. 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAB DRIVER		10b. KIND OF BUSINESS OR INDUSTRY Diamond Cab Co	
11. BIRTHPLACE (State or foreign country) ILLINOIS		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-20-1179	
17. INFORMANT ADELAIDE BARKER		Address 3817 58th AVE. HYATTSVILLE, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 420.0 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH minutes over 7 yrs
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 12-16-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county) Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE THEREOF 12-19-67	23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY	23d. LOCATION (City or Town) (County) (State) BLADENSBURG MD
24. FUNERAL DIRECTOR W.W. Chambers Co. RIVERDALE, MD.		25a. REC'D BY REGISTRAR DEC 21 1967	25b. REGISTRAR'S SIGNATURE John Charles Judge

MEDICAL CERTIFICATION

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

11287

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 83 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		d. STREET ADDRESS 630 Sheridan Street.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Fannie Middle C. Last Bartscher		4. DATE OF DEATH Month December Day 3 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-24-81
9. AGE (In years last birthday) yrs. 86		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Christopher Bartscher	
14. MOTHER'S MAIDEN NAME Ellen ?		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <input checked="" type="checkbox"/> No <input type="checkbox"/> unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Medical Record	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ADENOCARCINOMA OF COLON			INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Sept. 11, 1967 to Dec. 3, 1967 that (I) (we) last saw the deceased alive on Dec 3, 1967 , and that death occurred at 8:19 PM , from causes on and on the date stated above	
22a. SIGNATURE C. J. Houmann		22b. DATE SIGNED 12-3-67	
22c. PHYSICIAN'S NAME (Type) C. J. HOUMANN		22d. ADDRESS RIVERDALE MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/6/67	
23c. NAME OF CEMETERY OR CREMATORY Congressional		23d. LOCATION (City or Town) (County) (State) Washington D. C.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE DEC 11 1967	
25b. REGISTRAR'S SIGNATURE James Judge			

[illegible]

CHILDREN

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

1

13

9- 1

2415

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17419

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 5605 64th Ave.	
3. NAME OF DECEASED (Type or print) First Ortilie Middle Bastgen Last 		4. DATE OF DEATH Month Dec. Day 17 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 April 1884
9. AGE (In years last birthday) 83 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Illinois	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Max Heyer	
14. MOTHER'S MAIDEN NAME Ernstene Schmidt		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. 		17. INFORMANT Shirley M Adams Address Riverdale, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 48 hrs. 10 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (was hospital) attended the deceased from June , 1964, to Dec 17, 1967 that (I) (was) last saw the deceased alive on 16 Dec 1967 , and that death occurred 4, 16AM , from causes and on the date stated above.			
22a. SIGNATURE Thomas G Maloney M.D.		22b. DATE SIGNED 17 Dec 67	
22c. PHYSICIAN'S NAME (Type) Thomas G Maloney		22d. ADDRESS Woodlawn, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec 20, 1967	23c. NAME OF CEMETERY OR CREMATORY St. Lucas Cemetery	23d. LOCATION (City or Town) (County) (State) Chicago Cook Illinois
24. FUNERAL DIRECTOR F. Gasch's Sons		25a. REC'D BY REGISTRAR DATE DEC 21 1967	
ADDRESS Hyattsville, Md.		25b. REG STRAR'S SIGNATURE W. J. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14420

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 6401 Landover Road	
3 NAME OF DECEASED (Type or print) First Middle Last James G Beach		4 DATE OF DEATH Month Day Year 12 3 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12-14-1903
9 AGE (In years, mo., day) 63 yrs		10 IF UNDER 1 YEAR Months Days Hours Min 11 20	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired D.C. Policeman - D.C. GOVT.		11 BIRTHPLACE (State or foreign country) ARVONIA, VIRGINIA	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME Cecil Beach	
14 MOTHER'S MAIDEN NAME Eliza Toney (Beach)		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16 SOCIAL SECURITY NO ---		17 INFORMANT Mrs. Elsie F. Beach, wife - Rd., Hyatts-	
18 CAUSE OF DEATH (Enter only one cause per Part I. Death was caused by: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH minutes over 3 yrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f (City or town) (County) (State) Hyattsville, Md.
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 12-4-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b DATE THEREOF 12/4/1967	23c NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY	23d LOCATION (City or town) (County) (State) SUITLAND, MD
24 FUNERAL DIRECTOR William M. Hyatt Hyatt Funeral Home - 1300 N. ST. N.W.		25a REC'D BY REGISTRAR DATE DEC 6 1967	
		25b REGISTRAR'S SIGNATURE Charles Judge	

2 - 111 -

• •

• • •

• •

•

•

•

•

•

• • •

• • •

• • •

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

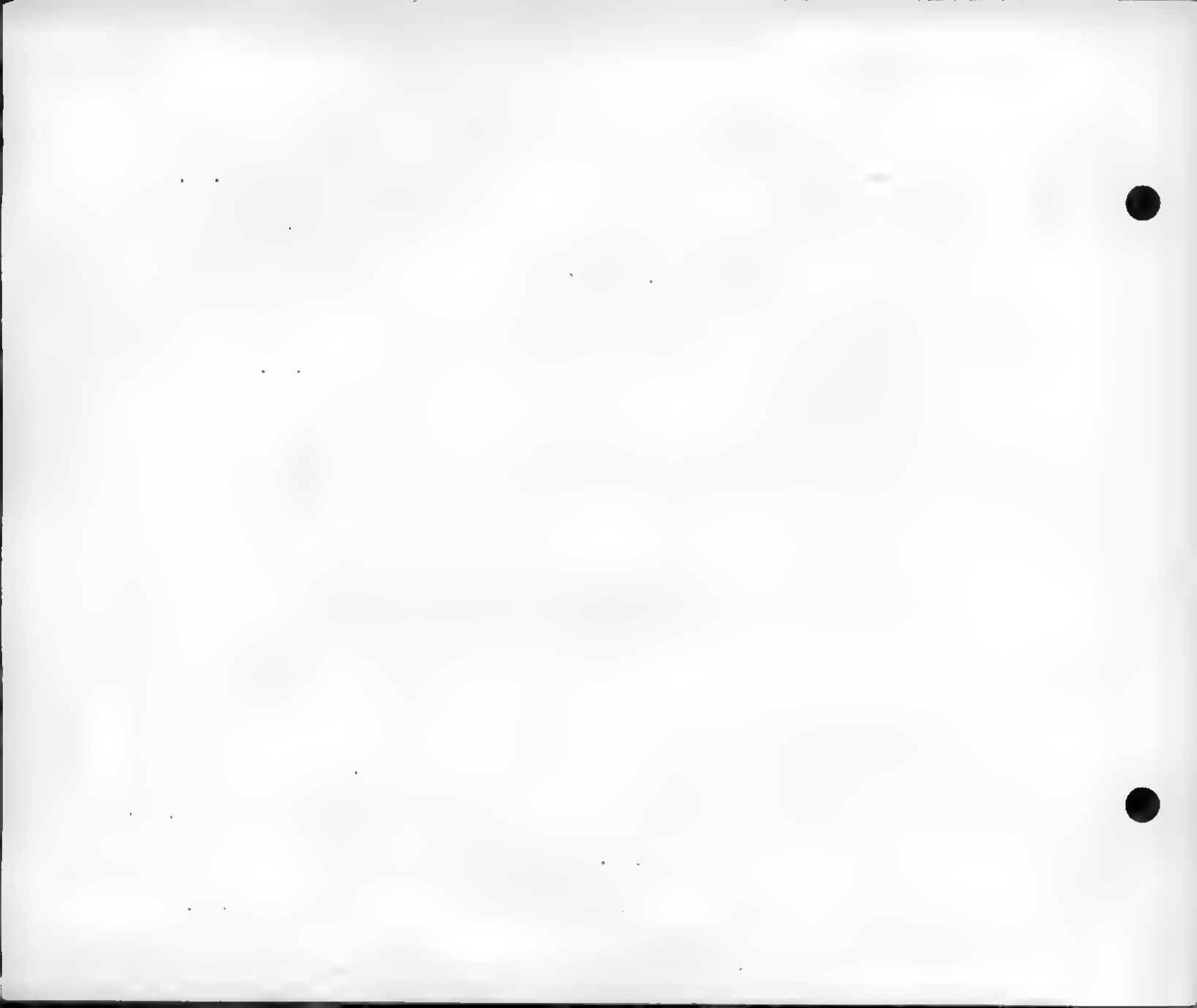
CERTIFICATE OF DEATH

11421

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Washington, D. C. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		d. STREET ADDRESS no fixed address	
3. NAME OF DECEASED (Type or print) First Bernard P. Middle H. Last Beavers		4. DATE OF DEATH Month 12 - Day 4 - Year 19 67	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/18/16
9. AGE (In years last birthday) 50 yrs		10. FUNDING YEAR Months 12 Days 4 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet metal worker		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Dalridge Beavers		14. MOTHER'S MAIDEN NAME Mary Ryder	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 578-16-5863	
17. INFORMANT decedent		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE VASCULAR-CEREBRAL BLEEDING. DUE TO GENERALIZED ARTERIO-SCLEROSIS. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) CONGESTIVE CARDIAC FAILURE. (c) CORONARY INSUFFICIENCY. PULMONARY EMPHYSEMA.		INTERVAL BETWEEN ONSET AND DEATH 2 days 12 days YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. B.T. NG <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 0 m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11/10/1967 to 12/4/1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12/4/1967 , and that death occurred 02:03 PM , from causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 12/4/67	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-7-1967	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Washington, D.C.
24. FUNERAL DIRECTOR Joseph Hawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash. D.C.		25a. REC'D BY REGISTRAR DEC 11 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the Death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11422

1 PLACE OF DEATH a COUNTY <u>PRINCE GEORGES</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORESTVILLE</u>				c LENGTH OF STAY IN 1b <u>10 days</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>REGENT Nursing & Rehabilitative Center</u>				d STREET ADDRESS <u>7313 BAYLOR AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM E. BEDELL</u>				4 DATE OF DEATH Month Day Year <u>12 19 1967</u>			
5 SEX <u>M</u>		6 COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>2-26-97</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REAL ESTATE Agent</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Agent</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Louisiana</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Charles W. Bedell</u>				14 MOTHER'S MAIDEN NAME <u>Lothe Keene</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16 SOCIAL SECURITY NO.		17 INFORMANT <u>Lucie Smith College Park, Md</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Paraplegia - Parkinson's disease</u>						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)			
20c TIME OF INJURY Month, Day, Year Hour 'o'm. p.m. <u>19</u>				20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f (City or town) (County) (State)			
21. I certify that (a) (this hospital) attended the deceased from <u>Dec. 9, 1967</u> , to <u>Dec. 19, 1967</u> , that (b) (we) last saw the deceased alive on <u>Dec. 19, 1967</u> , and that death occurred at <u>7:45 p.m.</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>W.D. Sheer</u>				22b. DATE SIGNED <u>Dec. 19, 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>WALTER B. SHEER</u>	
				22d ADDRESS <u>6400 MARLBORO PkE S.E. WASH. DC 20028</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec 21, 1967</u>		23c NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>		23d LOCATION (City or town) (County) (State) <u>Colmar Manor Pro Geo Md</u>	
24 FUNERAL DIRECTOR <u>F. Gasch's Sons Hyattsville, Md.</u>				25a REC'D BY REGISTRAR <u>DEC 27 1967</u>		25b REGISTRAR'S SIGNATURE	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

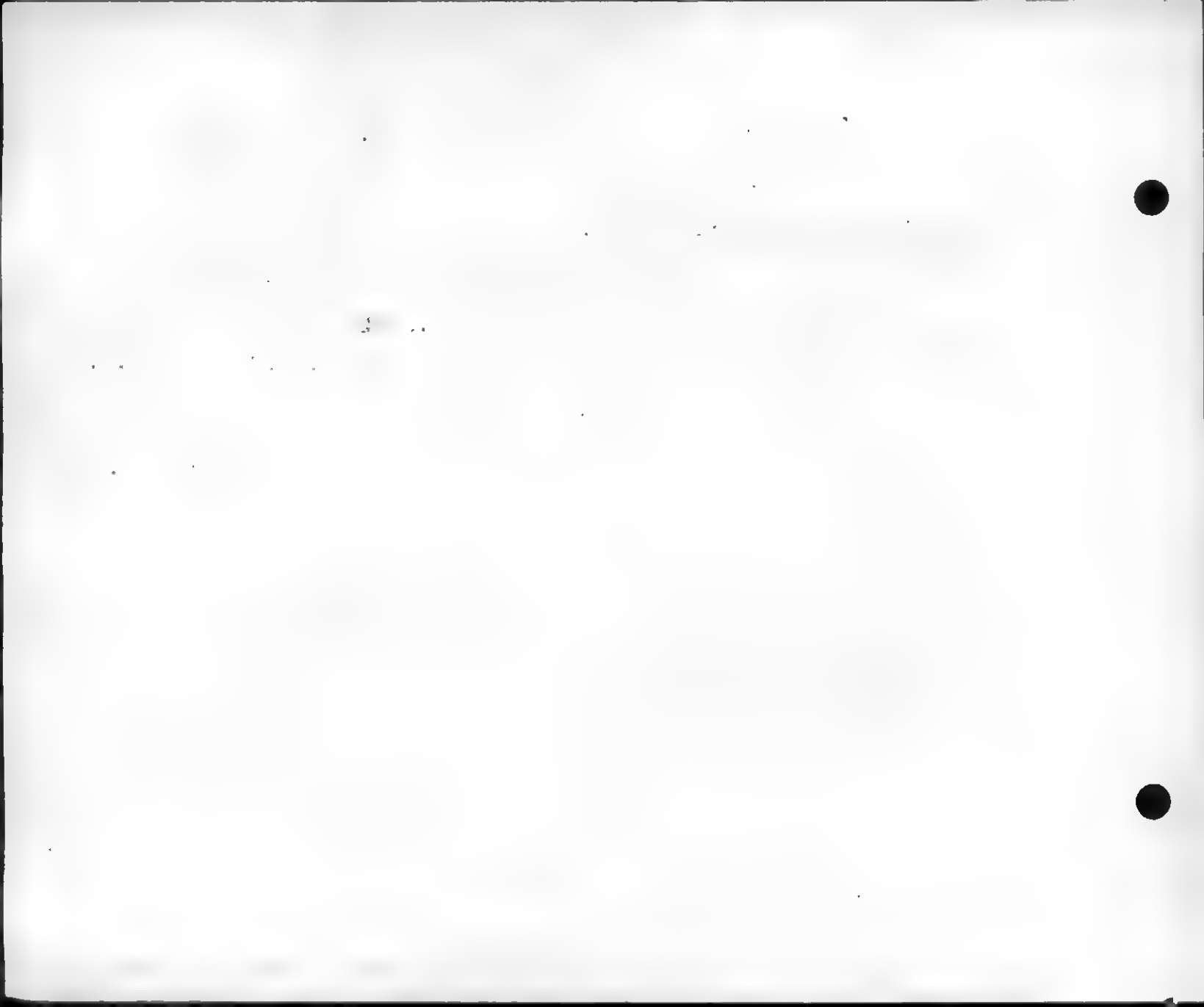
VR A15ME (3)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17423

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Md. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY in 1b DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hosp				e. STREET ADDRESS 208 Audrey Lane			
3. NAME OF DECEASED (Type or print) First Mary Middle Agnes Last Bell				4. DATE OF DEATH Month 12 Day 9 Year 1967			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 Dec., 1922	9. AGE (in years last birthday) 45 yrs	10. FUNERAL 1 YEAR Months 45 Days 12 Hours 9 Min 67		11. IF UNDER 24 HRS Months 45 Days 12 Hours 9 Min 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James Franklin Jacobs				14. MOTHER'S MAIDEN NAME Sadie Ferris			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT William C. Bell		Address 4418 Taney Avenue Alexandria, Va.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cirrhosis of liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS A TOLPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type)			M.D. Riverdale		22. DATE SIGNED 12-10-67		
23a. BURIAL CREMATION, REMOVAL (Specify)			23b. DATE THEREOF 12-12-1967		23c. NAME OF CEMETERY OR CREMATORY Washington Nat'l		23d. LOCATION (City or Town) (County) (State) Suitland, Md
24. FUNERAL DIRECTOR Robert A. Mattingly			ADDRESS Wash D.C.		25a. REC'D BY REGISTRAR DEC 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and return them to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last 2a. DATE OF DEATH Month Day Year 2b. HOUR

Rose L. Biggs December 30 1967 5:20 PM

3 SEX Female 4 RACE White 5 DATE OF BIRTH January 8, 1900 6. AGE (In years last birthday) 67 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN

7a. BIRTHPLACE (State or foreign country) Washington, D. C. 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 9. COUNTY OF DEATH Prince Georges Md

10 CITY OR TOWN OF DEATH Hyattsville 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hyattsville Nursing Home 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Sales Clerk - Retired 12b. KIND OF BUSINESS OR INDUSTRY Dept. Store

13a. USUAL RESIDENCE (Where deceased admsion) STATE lived, if instituton. Residence before 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET AND NUMBER

Wash. D. C. 4927 - 4th Street, N. W.

14. FATHER'S NAME First Middle Last 15. MOTHER'S MAIDEN NAME First Middle Last

Owen S. Lacey Rose Wilson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (na, or unknown) No (If yes give war or dates of service) 16b. SOCIAL SECURITY NO 579-14-1221-A 17 INFORMANT Norman E. Biggs 4927 - 4th Street, N. W. Washington, D. C.

18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of the Breast with metastasis
170x DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH nine yr's

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Rounded Pathologic Calcification

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☒ 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) 21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. 19 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d. INJURY OCCURRED While ☐ Nat while ☐ at work ☐ at work 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC) 21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (the hospital) attended the deceased from March 19 65 to Dec 30, 19 67, that (I) (we) last saw the deceased alive on September 20, 19 67, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

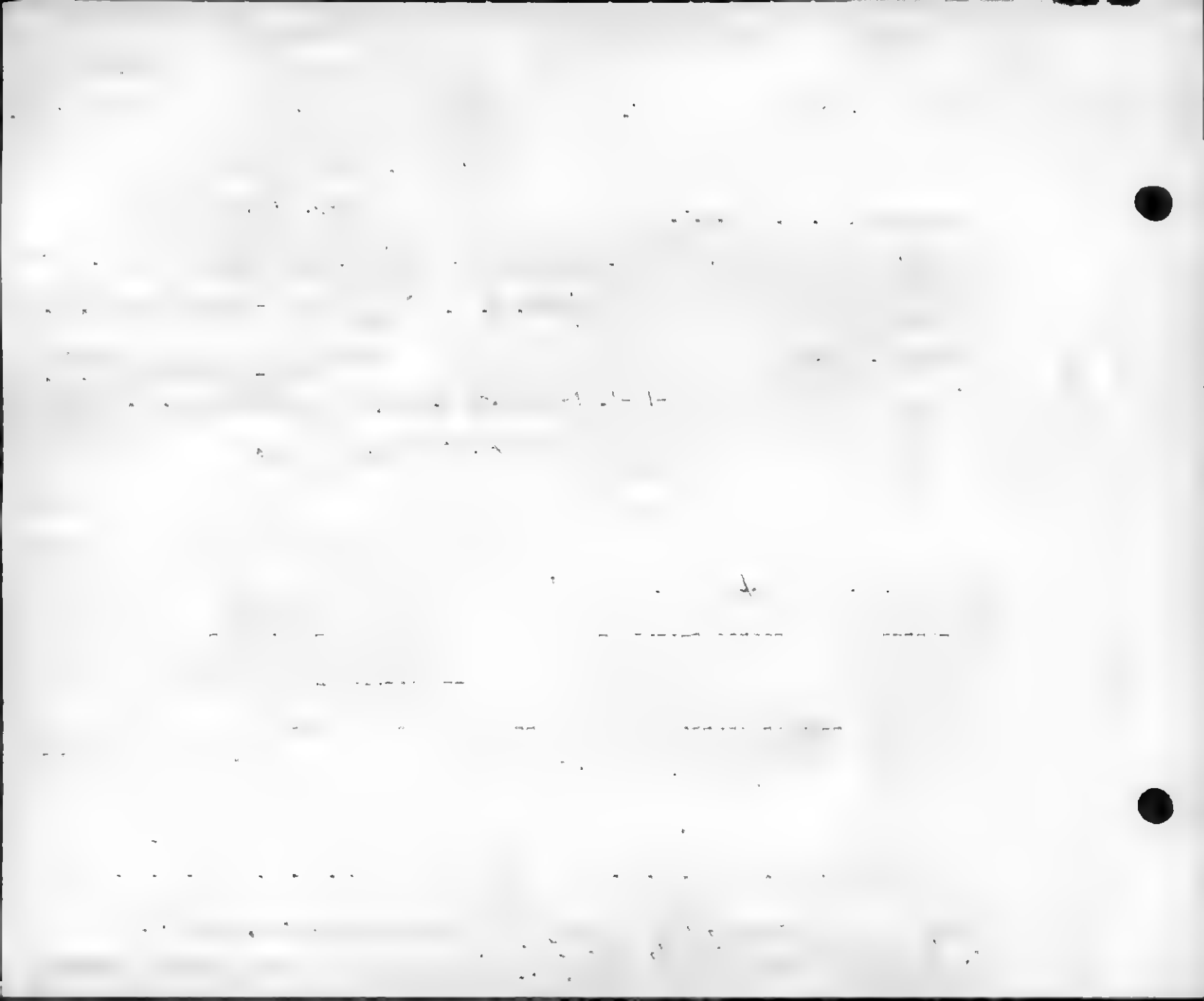
22b. SIGNATURE Warren D. Brill, MD DEGREE ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐ 22c. DATE SIGNED Jan 1, 1968

22d. PHYSICIAN'S NAME (Type) Warren D. Brill, M.D. 22e. ADDRESS 2201 16th St. N.E. Wash. D. C.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE January 3, 1968 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery 23d. LOCATION (City or Town) (County) (State) Suitland, Maryland

24. FUNERAL DIRECTOR (Name) Warner E. Humphrey, M.D. 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

8434 Georgia Avenue, Silver Spring, Md. DATE JAN 8 1968 Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17425

1. PLACE OF DEATH a COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Prince George's			
b CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) Andrews AFB			c LENGTH OF STAY IN 1b 5 Months		c CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) Hyattsville		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Malcolm Grow USAF Hospital				d STREET ADDRESS 2502 Queens Chapel Rd.		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last HARRY BERTRAM BLACKSTEN				4 DATE OF DEATH Month Day Year December 17 1967			
5 SEX Male		6 COLOR OR RACE Cauc		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 21 Aug 14	
				9 AGE (in years last birthday) yrs. 53		10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Intelligence Off. US Air Force				10b KIND OF BUSINESS OR INDUSTRY Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HARRY B. BLACKSTEN				14. MOTHER'S MAIDEN NAME DIMPLE A. KRAMER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes 1941-1967		16 SOCIAL SECURITY NO 275-09-1680		17 INFORMANT Official Records Address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of lungs DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 18 Aug 1967 , to 17 Dec 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 17 Dec 1967 and that death occurred at 5:30 PM from causes and on the date stated above							
22a SIGNATURE <i>John F. Lindeman</i>				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED 18 Dec 67	
22c. PHYSICIAN'S NAME (Type) JOHN F LINDEMAN, CAPT USAF				22d. ADDRESS MALCOLM GROW USAF HOSP ANDREWS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
Burial		12/21/67		Arlington Nat. Cem		Arlington, Virginia	
24 FUNERAL DIRECTOR Falls Church Funeral Home, Falls Church, Va.				25a. REC'D BY REGISTRAR DATE DEC 21 1967		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

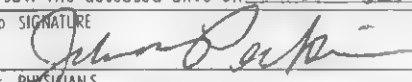
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



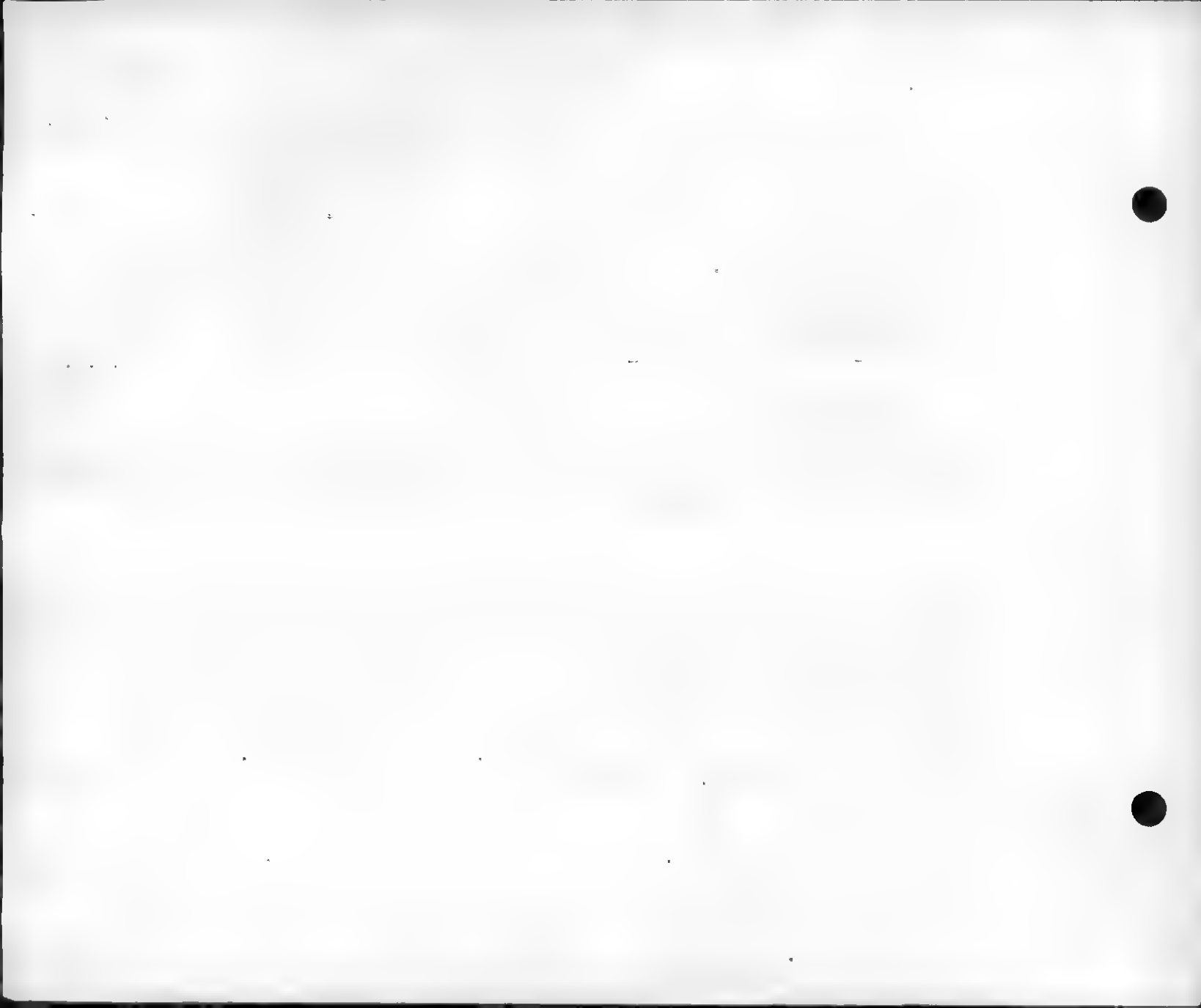
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11426

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY in lb 7 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 6105 85th Ave.	
3 NAME OF DECEASED (Type or print) Kimberley R. (Baby Girl) Blasi		4. DATE OF DEATH Month December Day 9 Year 1967	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 2, 1967
9. AGE (In years lost birthday) yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Prince George's, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Raymond Blasi		14. MOTHER'S MAIDEN NAME Rebecca Brookman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Mr. Raymond Blasi (above address)		Address	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage, Left Cerebrum & Cerebellum 760.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec. 2, 1967 , to Dec. 9, 1967 , that (I) (we) last saw the deceased alive on Dec. 9, 1967 , and that death occurred at 4:55 A.M. from causes on and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED 12-9-67	
22c. PHYSICIAN'S NAME (Type) John Perkins, M.D.		22d. ADDRESS 6201 Riverdale Rd., Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/12/67	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.	23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.
24. FUNERAL DIRECTOR Nailey's Funeral Home Inc.		25a. REC'D BY REGISTRAR DEC 13 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

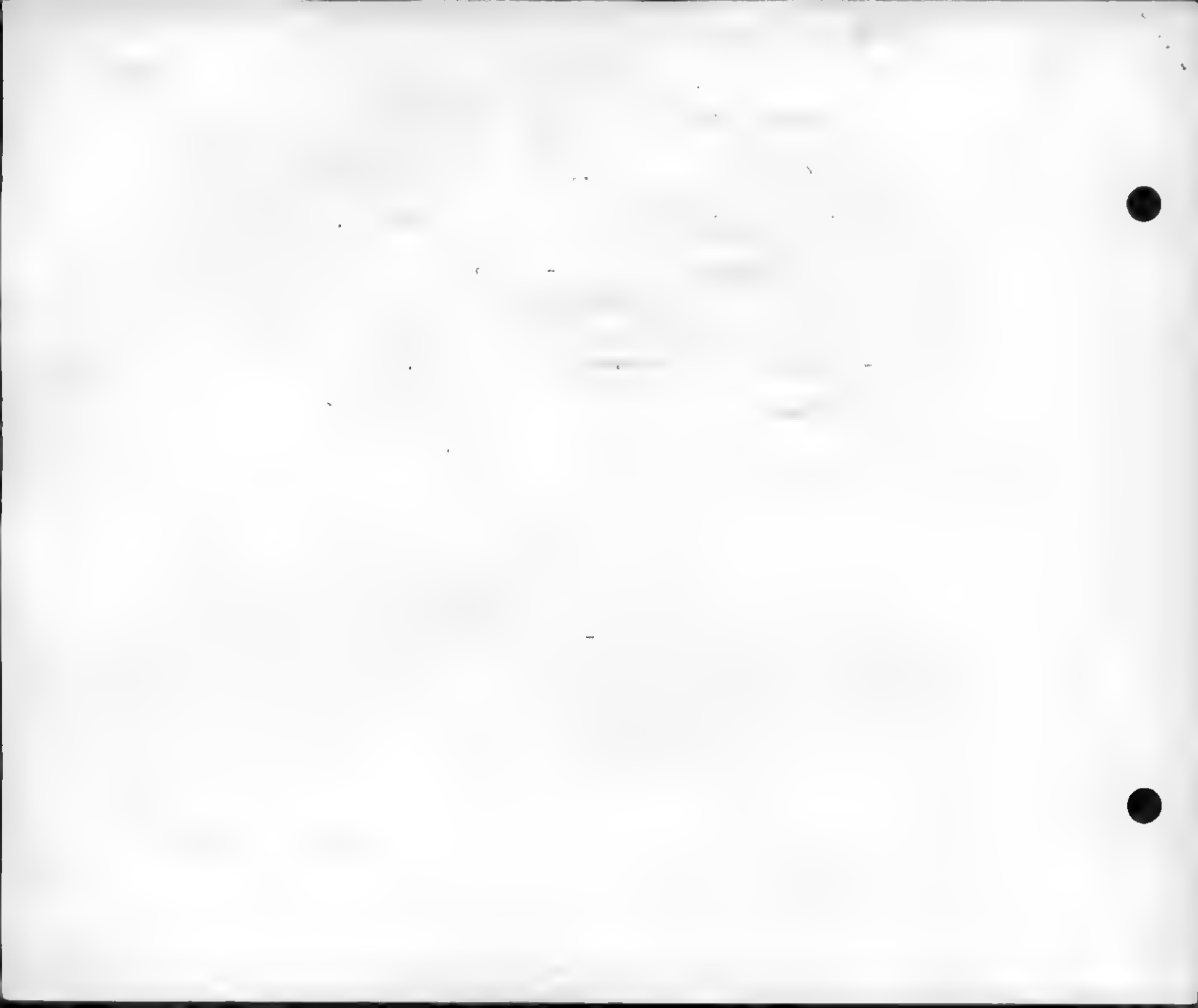
VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17427

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Washington, D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY in 1b 6 mos., 11 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Marigene Middle -- Last Boyd		4. DATE OF DEATH Month 12 Day 6 Year 1967	
5. SEX F	6. COLOR OR RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> separated <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/3/1918
9. AGE (In years last birthday) yrs 49		10. IF UNDER 1 YEAR Months 24 Days 11 Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown - retired		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (County & State, or foreign country) N. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Eugene Gaffney		14. MOTHER'S MAIDEN NAME Hattie Vance	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Coma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cirrhosis of the liver DUE TO (c) Chronic alcoholism		INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 2 years Years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Peripheral neuropathy - eight months		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (s) (this hospital) attended the deceased from 5/26/1967 to 12/6/1967 , that (s) (we) last saw the deceased alive on 12/6/1967 , and that death occurred at 5:45 AM , from causes and on the date stated above			
22a. SIGNATURE <i>Moe Weiss</i>		22b. DATE SIGNED 12/6/67	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 9, 1967	
23c. NAME OF CEMETERY OR CREMATORY Harmony Mem. Park		23d. LOCATION (City or town) (County) (State) Landover Md.	
24. FUNERAL DIRECTOR W. W. Chambers		25a. REC'D BY REGISTRAR DEC 11 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>			

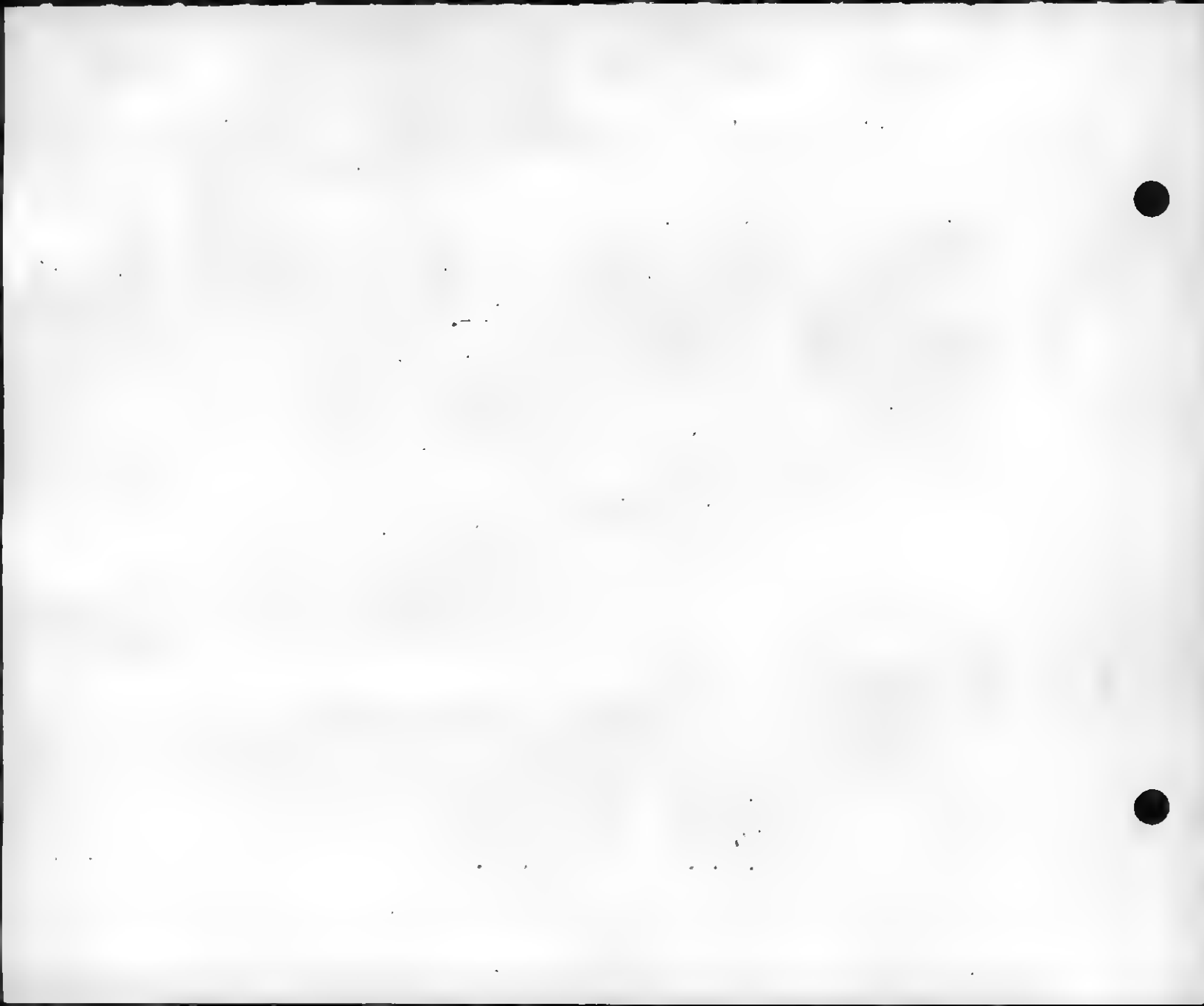


1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate must be executed within 48 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN IL DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Daniel Middle Emmitt Last Brady				4. DATE OF DEATH Month 12 Day 24 Year 19 67			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-25-1905	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DANIEL VAN BRADY				14. MOTHER'S MAIDEN NAME ELLA GILCREST			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 220-34-8163		17. INFORMANT RAYMOND L. BRADY	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH minutes unknown			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE John Kehoe, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 22. DATE SIGNED 12-26-67							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-27-67		23c. NAME OF CEMETERY OR CREMATORY ADDISON CHAPEL CEM.		23d. LOCATION (City, town or county) (State) SEAT PLEASANT MD.	
24. FUNERAL DIRECTOR W.W. Chambers Co. RIVERDALE, MD.				25a. REC'D BY REGISTRAR DATE JAN 2 1968			
				25b. REGISTRAR'S SIGNATURE			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form, PM-3. Page 5 may be retained for your files.

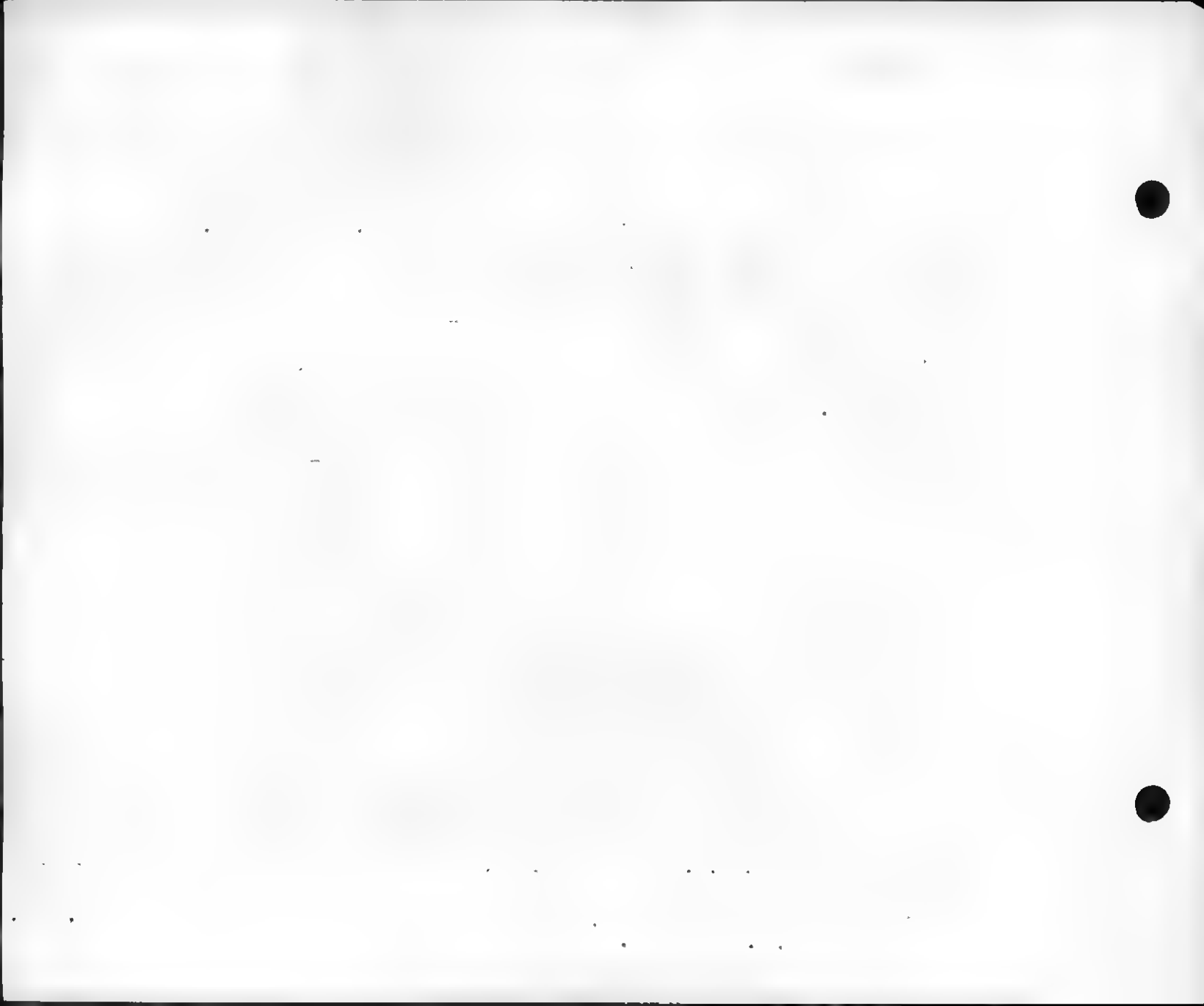
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1429

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY in 1b DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				e. STREET ADDRESS 5105 57th. Avenue, Apt. 304			
3. NAME OF DECEASED (Type or print) First Roger Middle William Last Bremner				4. DATE OF DEATH Month 12 Day 19 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-27-1965	9. AGE (In years last birthday) 2 yrs	IF UNDER 1 YEAR Months 12 Days 19 Hours 67		IF UNDER 24 HRS Hours 67 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, DC		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Raymond A. Bremner				14. MOTHER'S MAIDEN NAME Theresa Christopher			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO none		17. INFORMANT Theresa Bremner-same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Post Immersion Syndrome DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) SDII Aspiration of water DUE TO (c) Accident in bathtub						INTERVAL BETWEEN ONSET AND DEATH 12 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Found lying face down in bathtub full of water.					
20c. TIME OF INJURY Month, Day, Year 10 hour pm 12-18 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Bladensburg P.G. Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 12-20-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 12/22/67		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery Prince Georges Co. Md.		23d. LOCATION (City or town) (County) (State)	
24. FUNERAL DIRECTOR The S.H. Hines Co.		ADDRESS Washington, DC		25a. REC'D BY REGISTRAR DEC 26 1967		25b. REGISTRAR'S SIGNATURE Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

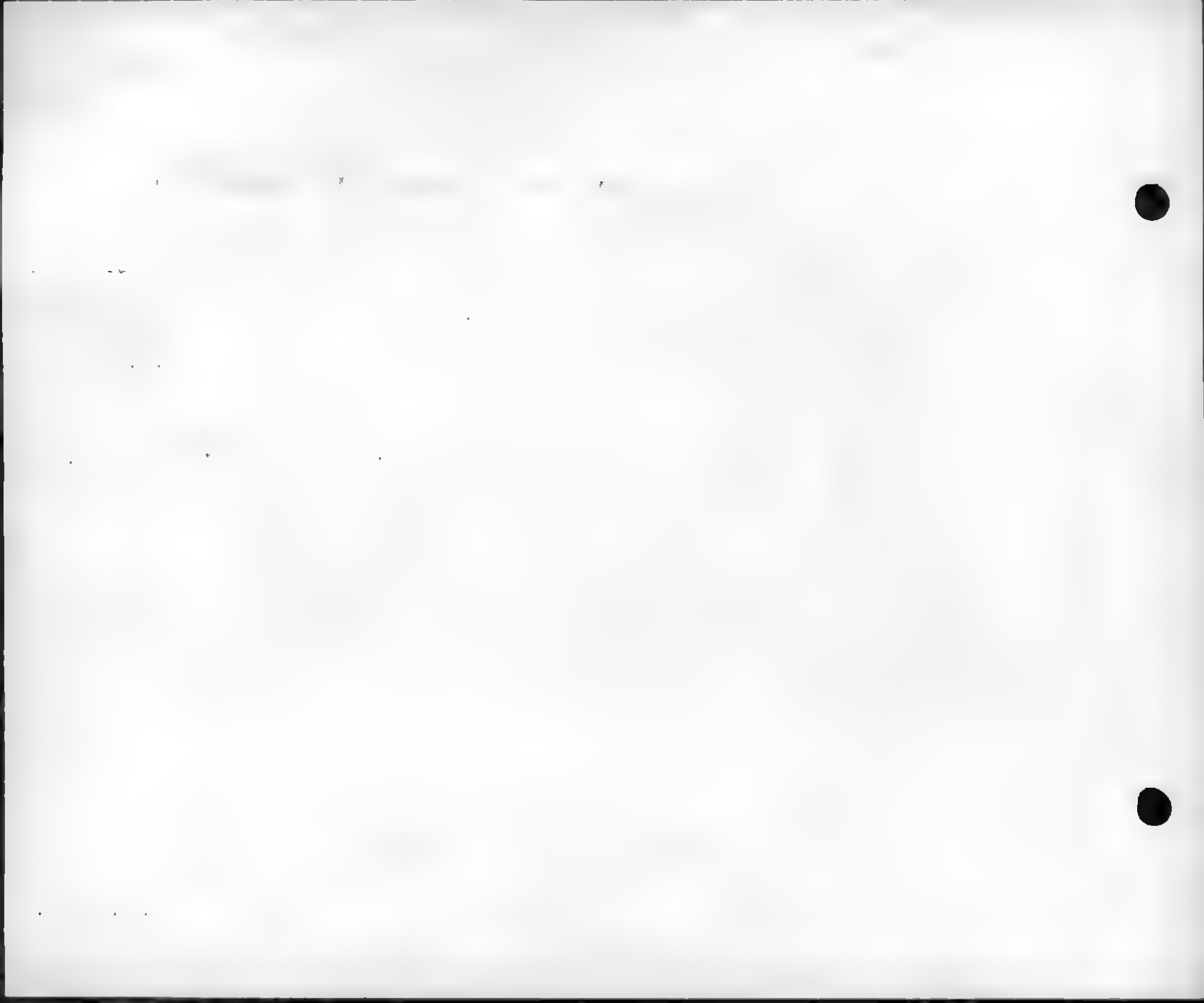
1427

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17430

1 PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, 16-1		d. STREET ADDRESS 5108 42nd Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Madison Manor Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last SARAH CATHERINE BROCK				4 DATE OF DEATH Month Day Year Dec. 25, 19 67			
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 16, 1872	9. AGE (In years last birthday) yrs. 95	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME John Fielder Tucker				14. MOTHER'S MAIDEN NAME Mary E. Thompson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 220 54 0806		17. INFORMANT Mrs. Inez B. Severe 6216 20th Place Hyattsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)						INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1964 , 19 to 12-25, 1967 , that (I) (we) last saw the deceased alive on 12-24, 1967 , and that death occurred at 1054 A.M., from causes and on the date stated above.							
22a. SIGNATURE Donald C. Edgren				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12-25-67	
22c. PHYSICIAN'S NAME (Type) DONALD C. EDGREN				22d. ADDRESS Hyattsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/28/67		23c. NAME OF CEMETERY OR CREMATORY George Washington		23d. LOCATION (City or Town) (County) (State) Hyattsville P. G. Md.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR DATE JAN 2 1968		25b. REGISTRAR'S SIGNATURE Charles Jones	



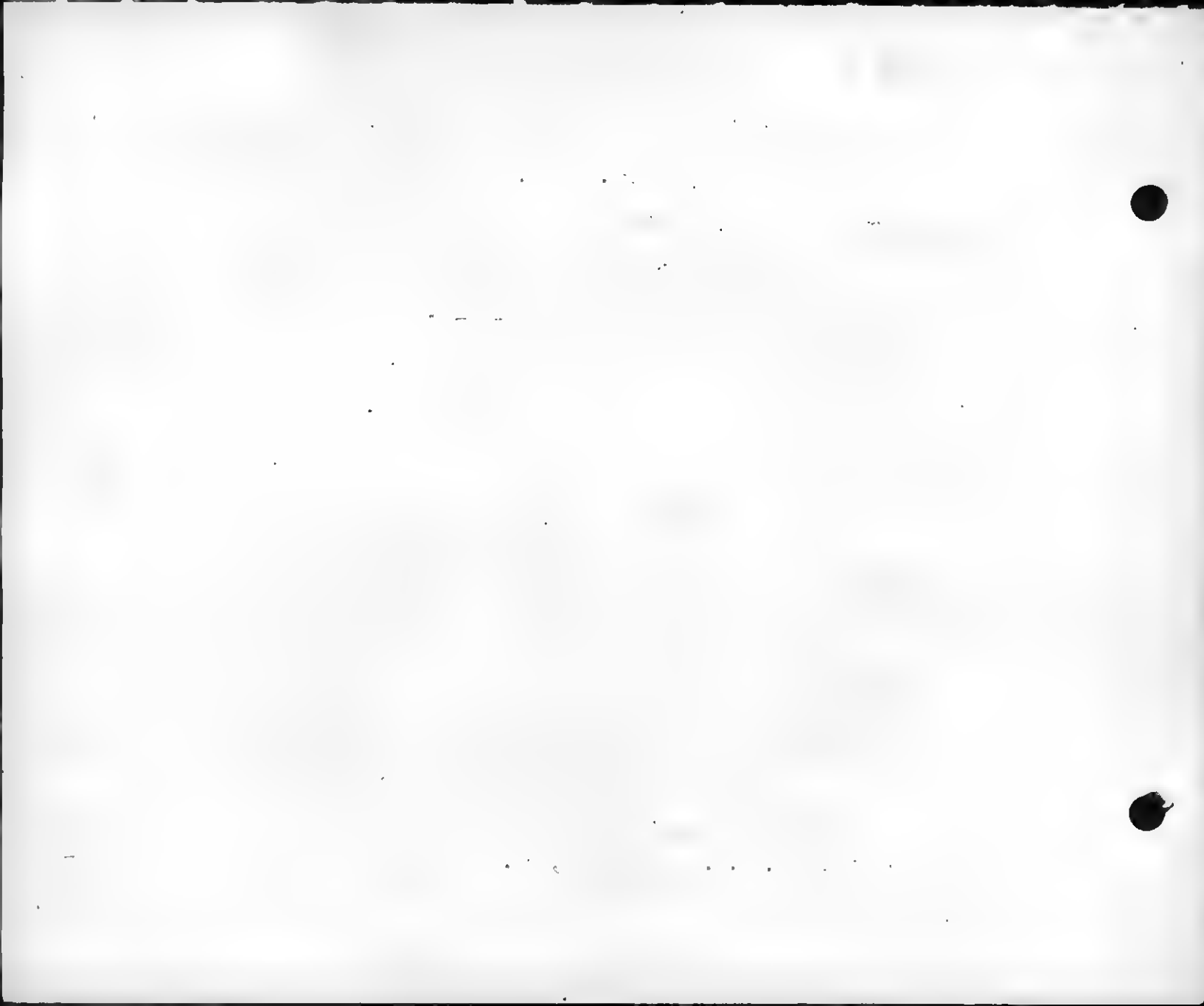
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 13 hrs. 15min.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		e. STREET ADDRESS 7512 Ridge Drive	
3. NAME OF DECEASED (Type or print) First Kathy Middle Denise Last Brown		4. DATE OF DEATH Month 12 Day 20 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-23-1967
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME DONALD L. BROWN		14. MOTHER'S MAIDEN NAME GLORIA J GREINER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT DONALD L. BROWN		Address 7512 RIDGE DRIVE KENTLAND MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction DUE TO Infarction of sigmoid colon by volvulus (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		22. DATE SIGNED 12-21-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-22-67	
23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEM.		23d. LOCATION (City, town or county) (State) COLMAR MANOR MD	
24. FUNERAL DIRECTOR W.W. CHAMBERS Co. RIVERDALE, MD.		25a. REC'D BY REGISTRAR DEC 26 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 11, 12, 13 & 14 File 3286 1/3/68 kk

CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Prince Georges Prince Georges	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN 1b 50 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d STREET ADDRESS Box 4610	
3 NAME OF DECEASED (Type or print) First Margaret Middle E Last Brown		4. DATE OF DEATH Month 22 Day Dec. Year 19 67	
5 SEX Female	6 COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH L June 1889
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) 78 yes
11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles H. Green		14 MOTHER'S MAIDEN NAME Mary Jackson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) gangrene of amputation stump R leg DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized arteriosclerosis DUE TO (c) diabetes mellitus			INTERVAL BETWEEN ONSET AND DEATH 6 weeks year 20 years
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) arteriosclerosis heart disease & coronary artery			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from Aug 18 , 1967, to Aug 22 , 1967, that (I) (we) last saw the deceased alive on Aug 22 , 1967, and that death occurred at 11:55 PM from causes and on the date stated above.			
22a SIGNATURE John H. Johnson		22b DATE SIGNED 12-24-67	
22c PHYSICIAN'S NAME (Type)		22d ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF 12-27-67	23c NAME OF CEMETERY OR PREMATORY Resurrection	23d LOCATION (City or Town) (County) (State) Clinton Md.
24 FUNERAL DIRECTOR Rollins 4339-Hunt Ph. NE	25a REC'D BY REGISTRAR DEC 27 1967	25b REGISTRAR'S SIGNATURE James J. Jones	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1743.3

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN TB DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 4519 41st. Avenue			
3. NAME OF DECEASED (Type or print) First Martha Middle E Last Brown				4. DATE OF DEATH Month 12 Day 3 Year 1967			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 April 1877	9. AGE (In years lost birthday) 90 YES	IF UNDER 1 YEAR Months 12 Days 3 Hours 19 Min 67		IF UNDER 24 HRS Months 12 Days 3 Hours 19 Min 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO		17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure 4 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH minutes years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS A TOLPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe M.D.				22. DATE SIGNED 12-4-67			
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 12-8-67		23c. NAME OF CEMETERY OR CREMATORY Harmony cemetery		23d. LOCATION (City or Town) (County) (State) Prince Geo County Md	
24. FUNERAL DIRECTOR John D. Watson ADDRESS 3435-14-51 Ave				25a. REF. BY REGISTRAR. DATE DEC 7 1967		25b. REGISTRAR'S SIGNATURE Charles J. Jones	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

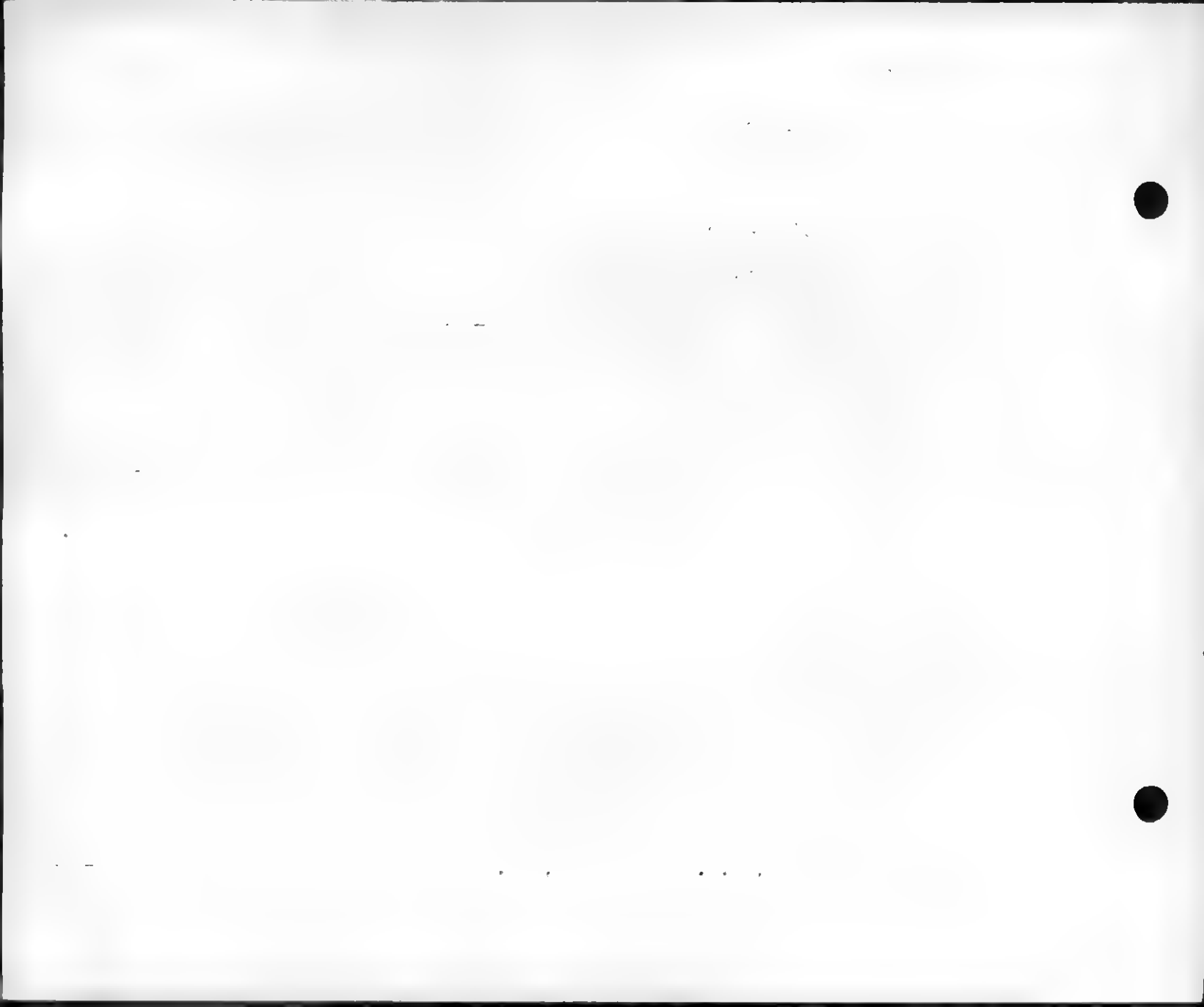
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS Fairmont Heights			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Monica Middle Ernestine Last Brown				4. DATE OF DEATH Month 12 Day 12 Year 1967			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-19-1962	9. AGE (in years last birthday) 5	10. FUNERAL YEAR Months 5 Days 12 Hours 19 Min. 67		11. UNDER 24 HRS Months 5 Days 12 Hours 19 Min. 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Bobby Vanfield				14. MOTHER'S MAIDEN NAME Laverne Brown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO None			
17. INFORMANT Laverne Brown Address Same as 2D							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory failure 341X DUE TO Bronchial asthma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) None DUE TO (c) None							INTERVAL BETWEEN ONSET AND DEATH 5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22. DATE SIGNED 12-13-67			
Address (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 12-16-67		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		23d. LOCATION (City or Town) (County) (State) Washington D.C.	
24. FUNERAL DIRECTOR H.S. Washington & Sons 4925 Drane Ave				25a. REC'D BY REGISTRAR DEC 18 1967			
ADDRESS				25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

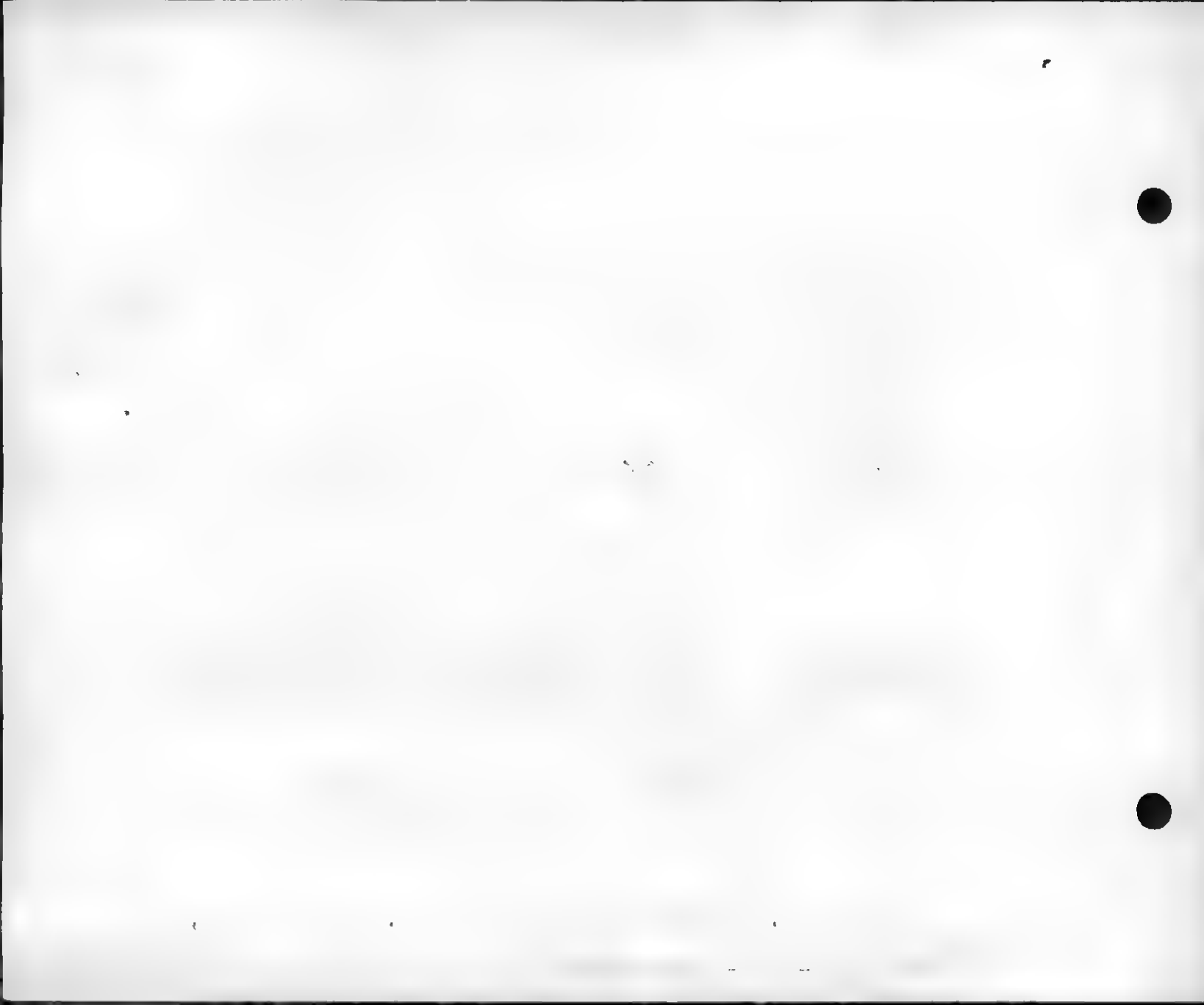
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17435

1 PLACE OF DEATH COUNTY <u>Prince Georges Co.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c LENGTH OF STAY IN 1b <u>5 mo.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pineview Gardens</u>		d STREET ADDRESS <u>4454 Leslie Ave.</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Jennie E. Buell</u>		4. DATE OF DEATH Month Day Year <u>December 29 1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1-14-83</u>
10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) yrs <u>84</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Washington DC</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>Edward Dunn</u>		14 MOTHER'S MAIDEN NAME <u>Christina Marks</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Unknown</u>		16 SOCIAL SECURITY NO <u>577 01 9676</u>	
17 INFORMANT <u>Mrs. Doris Schwarzman</u>		Address <u>Same as Item #2</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>PROBABLE MYOCARDIAL INFARCT</u> DUE TO (c) <u>ARTEROSCLEROTIC HEART DISEASE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>DAYS</u> <u>YEARS</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CVA, DIABETES - VEIN THROMBOSIS</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (If (this hospital) attended the deceased from <u>7-22</u> , 19 <u>67</u> to <u>12-29</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>12-29-1967</u> , and that death occurred at <u>8:35 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>R. LEW</u>		22b DATE SIGNED <u>12-29-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>RAYTH LEW D#3257</u>		22d. ADDRESS <u>PINEVIEW GARDENS</u>	
23a BURIAL, CREMATION, REMOVA. (Specify) <u>Burial</u>	23b DATE THEREOF <u>Jan. 2nd 1968</u>	23c NAME OF CEMETERY OR CREMATORY <u>Congressional Cem.</u>	23d LOCATION (City or Town) (County) (State) <u>Washington, DC</u>
24 FUNERAL DIRECTOR <u>Simmons Bros</u>		ADDRESS <u>Wash DC</u>	25a REC'D BY REGISTRAR <u>3 1968</u>
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>3 1968</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Medical examiner, Dr. John Kehoe, notified & approved

433
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY in lb D. O. A.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East Riverdale	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 6010 Carters Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gertrude Middle F. Last Burkley				4. DATE OF DEATH Month Dec. Day 10 Year 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 27, 1899	
9. AGE (in years last birthday) 68 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk		10b. KIND OF BUSINESS OR INDUSTRY Geograph. Soc.		11. BIRTHPLACE (County & State, or foreign country) Washington D. C.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Charles F. Fenwick Sr.			
14. MOTHER'S MAIDEN NAME Dora H. Erdmann				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			
16. SOCIAL SECURITY NO. 220 54 0169				17. INFORMANT Lloyd F. Burkley Same as #2 (husband)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS						INTERVAL BETWEEN ONSET AND DEATH IMMED. + 20 UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3 10 , 19 67 , to Present , that (I) (we) last saw the deceased alive on 11 17 , 19 67 , and that death occurred at 7:38 A.M. on causes and on the date stated above.							
22a. SIGNATURE C. J. Houmann				22b. DATE SIGNED 11 DEC 67		22c. PHYSICIAN'S NAME (Type) C. J. HOUMANN	
22d. ADDRESS RIVERDALE MD.				22e. ADDRESS RIVERDALE MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/13/67		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Colmar Manor P. G. Md.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR DATE DEC 18 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE HEALTH DEPT.

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Waldorf	
c. LENGTH OF STAY IN b. 15 hrs.		d. STREET ADDRESS Rt. 2 Box 227	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Robert Butler		4. DATE DEATH December 27 19 67	
5. SEX male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 7, 1902
9. AGE (In years, last birthday) 65 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Charles County, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John R. Butler		14. MOTHER'S MAIDEN NAME Mary Ann McPherson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac tamponade DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Perforation of heart (thoracentesis) (c) Arteriosclerotic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. INTERVAL BETWEEN ONSET AND DEATH 1 hour		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Myocardium perforated during thoracentesis.	
20c. TIME OF INJURY Month, Day, Year 5:30PM a.m. 12-27 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cardiac Intensive Care Unit -- see # 1		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kenoe, M.D.		22. DATE SIGNED 12-29-67	
EXAMINER'S NAME (Type) John Kenoe, M.D.		23a. CITY, Md. or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF Jan. 1-1968	23c. NAME OF CEMETERY OR CREMATORY St. Paul's Epis. Ch. Cem. Poolesville, Md.	
23d. LOCATION (City, town or county) (State) Poolesville, Md.		23e. REC'D BY REGISTRAR JAN 3 1968	
24. FUNERAL DIRECTOR Martell Adams Agawam, Md.		25a. REGISTRAR'S SIGNATURE Charles J. J...	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

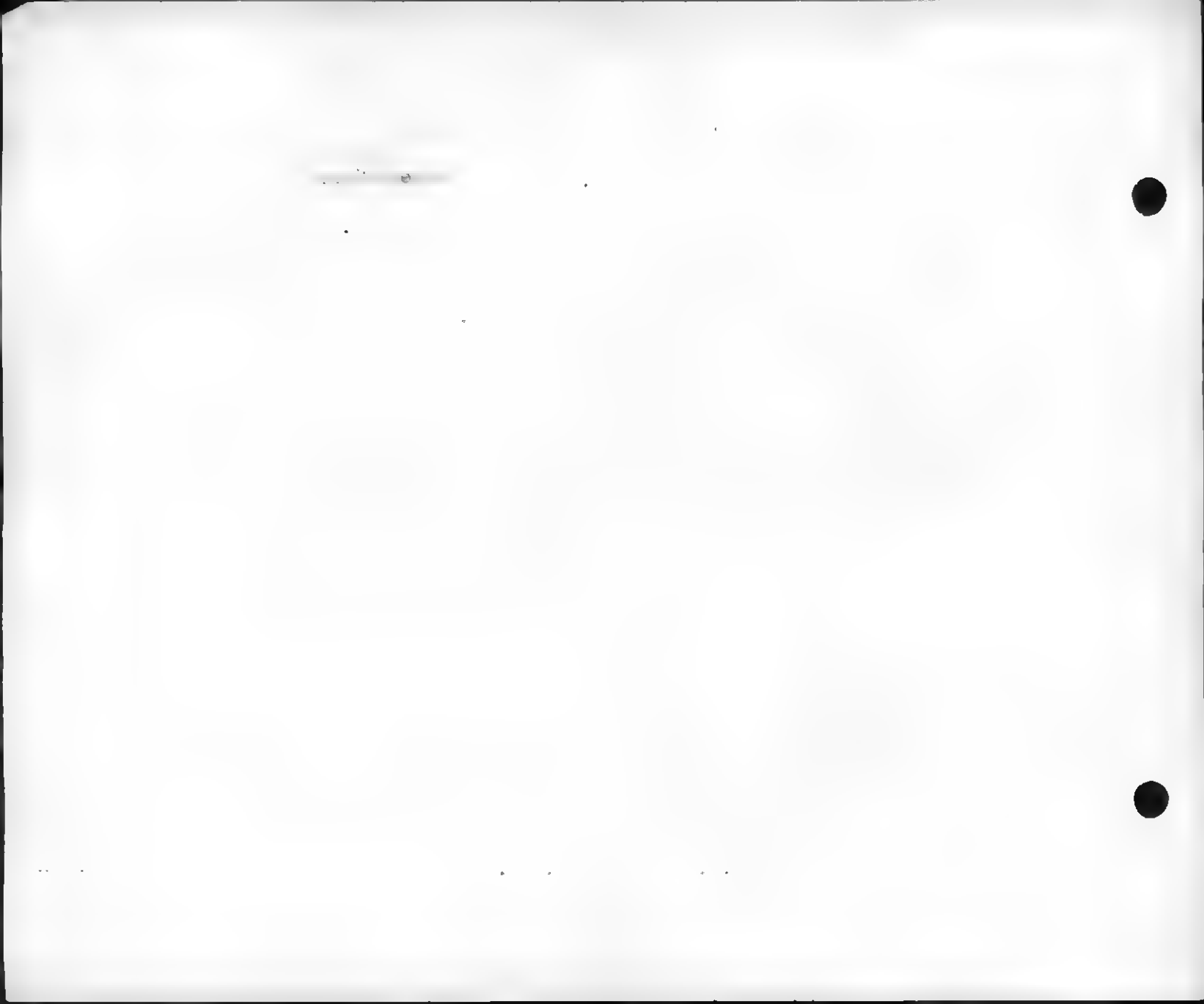
VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17438

1 PLACE OF DEATH a COUNTY <u>Prince George's</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Prince George's</u>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Cheverly</u>		c LENGTH OF STAY IN b <u>1 Hr. 25 min</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>		d STREET ADDRESS <u>Box 120, Rt. 2</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>John E Byrd</u>		4 DATE OF DEATH Month Day Year <u>12 18 19 67</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Negro</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>5-20-1945</u>
9 AGE (In years last birthday) <u>22</u>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during last 30 working days, even if retired) <u>Clerk</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Montgomery Ward</u>	
11 BIRTHPLACE (State of foreign country) <u>U.S.A.</u>		12 CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13 FATHER'S NAME <u>Robert L. Byrd</u>		14 MOTHER'S MAIDEN NAME <u>Lillie Mae Harris</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes Vietnam 1964-1967</u>		16 SOCIAL SECURITY NO. <u>13-428064</u>	
17 INFORMANT <u>Robert L. Byrd</u>		Address <u>Mitchellville</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun shot wound of chest and abdomen</u> <u>781X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Shot during altercation</u>	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>10:15 PM</u> <u>12-17-19 67</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Home</u>		20f (City or town) (County) (State) <u>Same as #2</u>	
21. I certify that I took charge of the remains described above held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.		22. DATE SIGNED <u>12-18-67</u>	
EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u>		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>12-22-1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Balto. Natl.</u>	23d LOCATION (City or town) (County) (State) <u>Balto. Md.</u>
24 FUNERAL DIRECTOR <u>William Beesett</u>		25a REC'D BY REGISTRAR <u>Anna M.</u> 25b REGISTRAR'S SIGNATURE <u>Anna M.</u>	
ADDRESS <u>Anna M.</u>		DEC 20 1967	



10 1

436

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17439

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN Id 9 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		d. STREET ADDRESS 4000 Nicholson Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bertie M Caffrey		4. DATE OF DEATH Month 12 Day 9 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/25/01
9. AGE (In years - last birthday) yrs. 66		10. IF UNDER 1 YEAR Months Days Hours Min	
11. OCCUPATION (Give kind of work done during most of working life, even if retired) Retired health, Ed. & Welf.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George L. Beard		14. MOTHER'S MAIDEN NAME Grace Virginia Gheen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 578 54 1853	
17. INFORMANT Admitting Record		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Massive Cerebral Hemorrhage</i> DUE TO (b) <i>Arteriosclerosis, chronic</i> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 9 days years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12/1, 1967, to 12/9, 1967, that (I) (we) last saw the deceased alive on 12/9, 1967, and that death occurred at 2:50 P.M. from causes and on the date stated above			
22a. SIGNATURE <i>Charles L. Purdy</i>		22b. DATE SIGNED 12/9/67	
22c. PHYSICIAN'S NAME (Type) C. L. Purdy, M.D.		22d. ADDRESS Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/12/67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill	23d. LOCATION (City or Town) (County) (State) Suitland P.G. Md.
24. FUNERAL DIRECTOR Francis Gasch's Sons		25a. REC'D BY REGISTRAR DEC 13 1967	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.



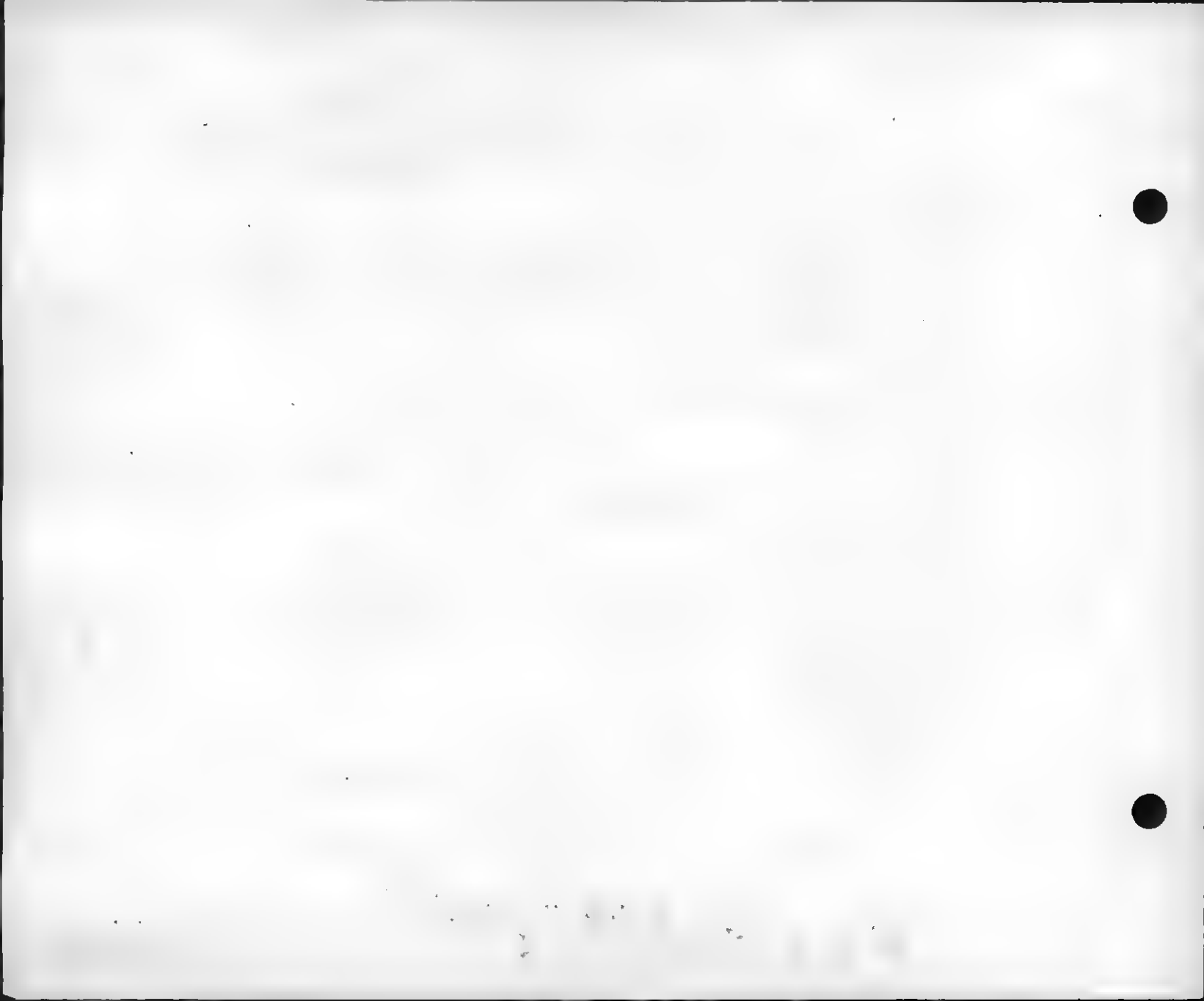
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11449

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S	
b. CITY OR TOWN (If outside corporate limits, write "RURAL" and give nearest town) ANDREWS AIR FORCE BASE		c. LENGTH OF STAY IN 1b 2 HRS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MALCOLM GROW USAF HOSPITAL		e. STREET ADDRESS 3430 LORRING DR.	
3. NAME OF DECEASED (Type or print) First JAMES Middle JOHN Last CARBONARI		4. DATE OF DEATH Month DECEMBER Day 3 Year 19 67	
5. SEX MALE	6. COLOR OR RACE CAUC	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 DEC 67
9. AGE (In years last birthday) 2 yrs		10. IF UNDER 1 YEAR Months 2 Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10b. KIND OF BUSINESS OR INDUSTRY PRINCE GEORGE'S MD	
11. BIRTHPLACE (County & State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES JOHN CARBONARI		14. MOTHER'S MAIDEN NAME MARIAN CARLANO	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO MARIAN CARBONARI SAME AS ITEM #2	
17. INFORMANT MARIAN CARBONARI SAME AS ITEM #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PREMATURE INFANT DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 116X		INTERVAL BETWEEN ONSET AND DEATH 2HRS 1MIN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 0138 3Dec 19 67 to 0339 3Dec 19 67 that (I) (we) last saw the deceased alive on 3 Dec 19 67 , and that death occurred at 3:39AM on 3 Dec 19 67 at the place and on the date stated above.			
22a. SIGNATURE <i>John Bristow M.D.</i>		22b. DATE SIGNED 3 Dec 67	
22c. PHYSICIAN'S NAME (Type) JOHN W BRISTOW, CAPT USAF		22d. ADDRESS MALCOLM GROW USAF HOSP ANDREWS AFB	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 5 Dec 67	
23c. NAME OF CEMETERY OR CREMATORY FREEDOM CREMATION		23d. LOCATION (City or Town) (County) (State) WASHINGTON, D.C.	
24. FUNERAL DIRECTOR <i>Carl F. Cuyper</i>		25a. REC'D BY REGISTRAR DATE JAN 5 1968	
25b. REGISTRAR'S SIGNATURE <i>Charles J. [unclear]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1441

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pr. Geo. General Hosp.		d. STREET ADDRESS 6821-Briarcliff Dr SE	
3. NAME OF DECEASED (Type or print) First Chen Middle M. Last CARLAN		4. DATE OF DEATH Dec. 31st 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28-1892
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd.		10b. KIND OF BUSINESS OR INDUSTRY Washington Terminal	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Carlan		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT June O. Selby-Same as Item #2		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Stroke 5102 DUE TO Intestinal obstruction with Gangrene Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO INFARCTION OF LARGE BOWEL (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12-30 , 19 67 , to 12-31 , 19 67 , that (I) (we) last saw the deceased alive on 12-31 , 19 67 , and that death occurred at 10:10 AM , from causes and on the date stated above.			
22a. SIGNATURE R. L. Longoria		22b. DATE SIGNED Dec. 31-67	
22c. PHYSICIAN'S NAME (Type) R. Longoria, M.D.		22d. ADDRESS Prince Geo. General Hospital	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan 4-1968	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland, Maryland
24. FUNERAL DIRECTOR Simmons Bros.		25a. REC'D BY REGISTRAR Jan 3 1968	
ADDRESS Wash DC		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
Simmons Bros. 1661-Good Hope RD SE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17442

1 PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 31 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington Suitland, Md. 20023 d. STREET ADDRESS 5813 Skyline Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lorraine C. Carroll		4. DATE OF DEATH Dec. 19, 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 8, 1920
9 AGE (In years, last birthday) 47 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John D. Bradley	
14. MOTHER'S MAIDEN NAME Catherine Wobst		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO		17. INFORMANT Kenneth Lee Carroll Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lung with cerebral metastasis DUE TO (b) several months DUE TO (c) 63x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (we) attended the deceased from 11/16 , 19 67 , to Dec. 19, 1967 , that (I) (we) last saw the deceased alive on Dec. 19, 1967 , and that death occurred at 12:00M , from causes and on the date stated above			
22a. SIGNATURE Frederick H. Wilhelm		22b. DATE SIGNED DEC 19, 1967	
22c. PHYSICIAN'S NAME (Type) Frederick H. Wilhelm, M. D.		22d. ADDRESS 6319 Landover Rd. Cheverly, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/22/67	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City or Town) (County) (State) Suitland Md	
24. FUNERAL DIRECTOR LEE FUNERAL HOME		25a. REC'D BY REGISTRAR DEC 26 1967	
ADDRESS 3004 ITNE		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FOR STATE
HEALTH DEPT.

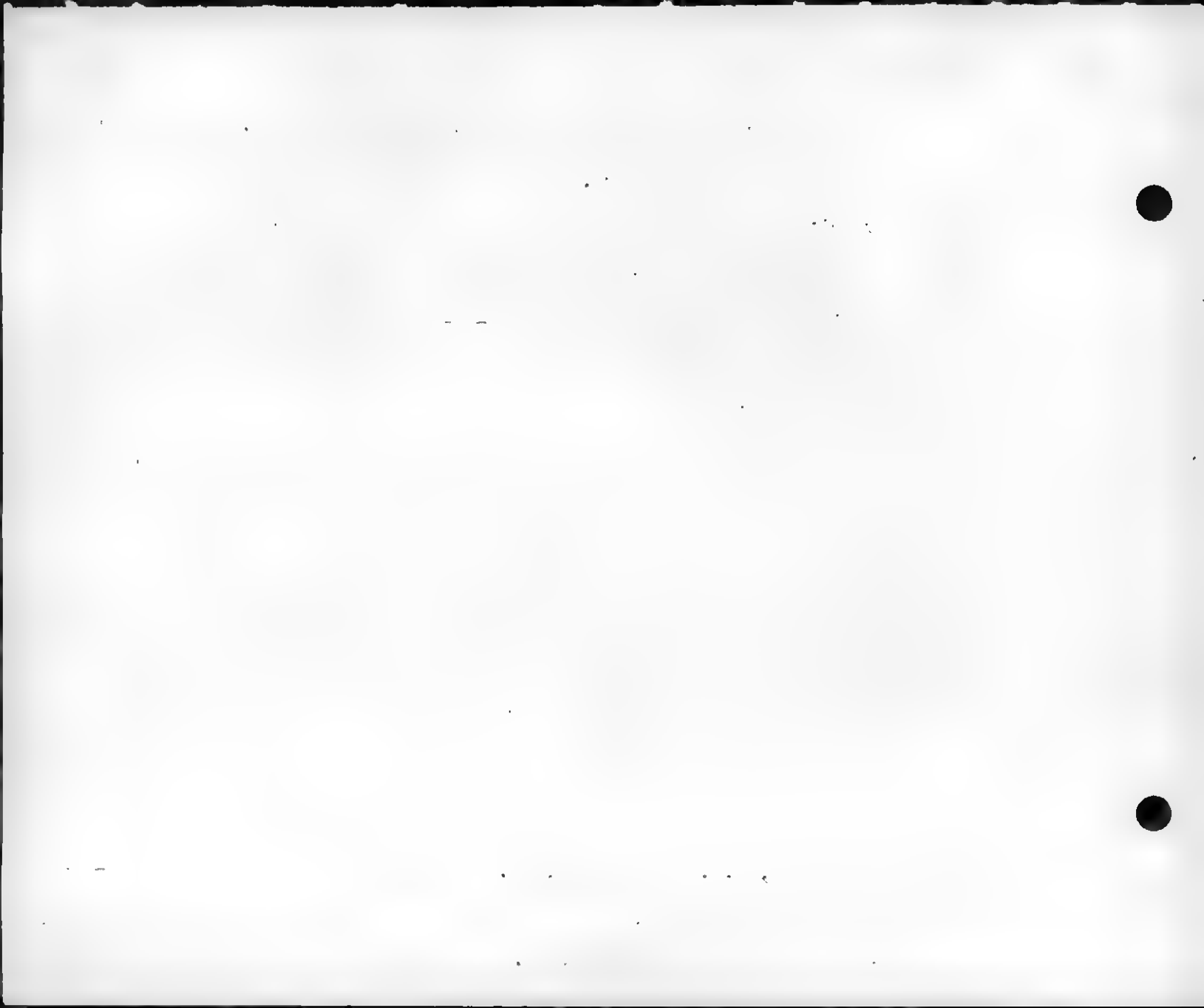
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 film 397

2-16-65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN b 12 hrs. 30 min	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham		d. STREET ADDRESS 9527 Lanham Severn Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert Eugene Carter Jr		4. DATE OF DEATH Month 12 Day 19 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-18-1967
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9b. AGE (In years last birthday) yrs. 5 Months 5 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Robert E Carter sr		14. MOTHER'S MAIDEN NAME Betty Hazel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Robert E Carter Sr		Address Lanham, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 1120 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SDII DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		22. DATE SIGNED 12-19-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 22, 1967	
23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City, town or county) (State) Colmar Manor Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DEC 27 1967	
25b. REGISTRAR'S SIGNATURE [Signature]		DATE	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY Prince Georges MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c LENGTH OF STAY IN 1b DOA d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Prince Georges c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Hyattsville d STREET ADDRESS 5352 Quincy Place e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Edward Middle J. Last Cauthers			4 DATE OF DEATH Month Dec. Day 14 Year 1967				
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH AUG 26, 1907	9 AGE (In years last birthday) 60 yrs IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min 0 IF UNDER 24 HRS: Hours 0 Min 0	10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SPECIAL POLICE 10b KIND OF BUSINESS OR INDUSTRY GIANT FOOD CO.		
11 BIRTHPLACE (County & State, or foreign country) WASHINGTON, D.C. 12 CITIZEN OF WHAT COUNTRY? U.S.			13 FATHER'S NAME ALBERT ERNEST CAUTHERS 14 MOTHER'S MAIDEN NAME MINNIE TATE				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES W.W.II		16 SOCIAL SECURITY NO 579 162947	17 INFORMANT Mrs. MARY C. CAUTHERS Address SAME AS #2				
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute coronary infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis of the heart disease (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH		
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town) (County) (State)				
21. I certify that (I) (in hospital) attended the deceased from 12-14 , 19 67 to 12-14 , 19 67 that (I) (yes) last saw the deceased alive on 12-14 , 19 67 , and that death occurred at 4:30 M, from causes and on the date stated above							
22a SIGNATURE George Hageage		22b DATE SIGNED 12-15-67	22c PHYSICIAN'S NAME (Type) George Hageage, M.D. 22d ADDRESS 3717 38th Ave., Cottage City, Maryland				
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF Dec 19, 1967	23c NAME OF CEMETERY OR CREMATORY Oak Grove Cem.	23d LOCATION (City or Town) (County) (State) GREENVILLE, TENN.				
24 FUNERAL DIRECTOR W. W. Chamber		25a REG. BY REGISTRAR DEC 21 1967	25b REGISTRAR'S SIGNATURE <i>[Signature]</i>				



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17445

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 45 m		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 4918 Powder Mill Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Joseph Middle A Last Chaney Jr				4. DATE OF DEATH Month Dec. Day 16 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 May 1903		9. AGE (in years last birthday) 64 yrs	10. IF UNDER 1 YEAR Months 11 Days 1 Hours 1 Min 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY P E P Company		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Joseph Chaney				14. MOTHER'S MAIDEN NAME Julia A Beckett			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 577 09 3917		17. INFORMANT Name Ruth C Chaney Address Beltsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4001 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/15 , 19 67 , to 12/16 , 19 67 that (I) (we) last saw the deceased alive on 12/16 19 67 , and that death occurred at 11:45 PM , from causes and on the date stated above.							
22a. SIGNATURE <i>[Signature]</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/16/67	
22c. PHYSICIAN'S NAME (Type) Dr. R. Deitz, M.D.				22d. ADDRESS Beltsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 19, 1967		23c. NAME OF CEMETERY OR CREMATORY St John's Cemetery		23d. LOCATION (City or Town) (County) (State) Beltsville Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR DEC 21 1967		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the Death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

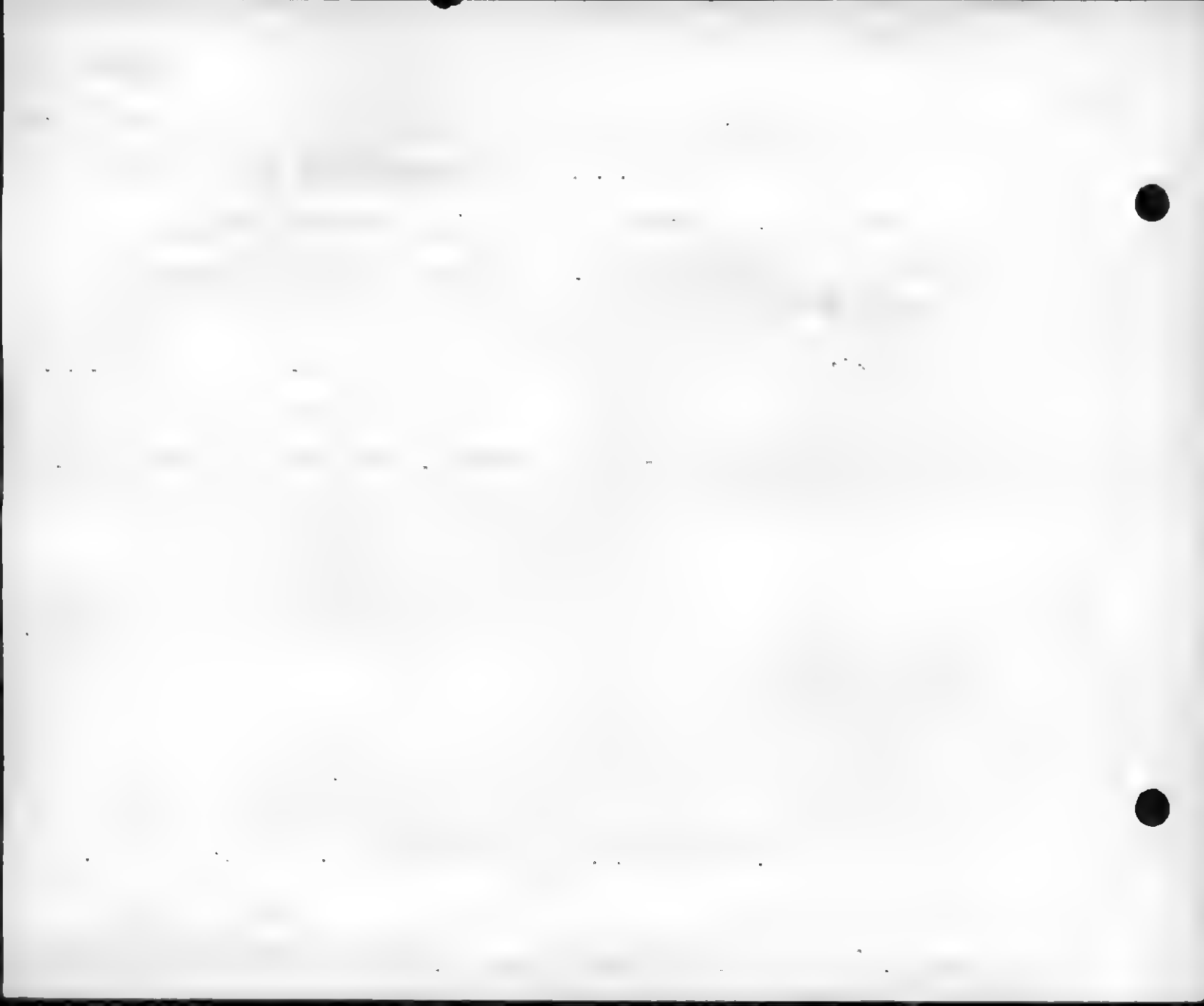
CERTIFICATE OF DEATH

17446

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institut on Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH-OF STAY IN 1b D.O.A.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 7309 Longbranch Drive			
3. NAME OF DECEASED (Type or print) First Jesse Middle U. Last Chappelear				4. DATE OF DEATH Month December Day 1 Year 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/3/90	
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min 		11. IF UNDER 24 HRS Months Days Hours Min 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Cochran				14. MOTHER'S MAIDEN NAME Annette Vernon			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO 220-44-7445		17. INFORMANT Vernon C. Chappelear Address 4314 Tuckerman St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Cardiac Arrest T x u i DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Coronary Occlusion DUE TO (c) Arteriosclerotic Cardiovascular Disease				INTERVAL BETWEEN ONSET AND DEATH 4 min 5 min 10 years			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June , 19 60 , to Dec. 1 , 19 67 , that (I) (we) last saw the deceased alive on Nov 30 , 19 67 , and that death occurred at 11:45 , from causes and on the date stated above.							
22a. SIGNATURE Thomas G. Maloney M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 12/2/67	
22c. PHYSICIAN'S NAME (Type) Thomas G. Maloney, M.D.				22d. ADDRESS 4814 71st Ave., Landover Hills, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/5/67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland Maryland	
24. FUNERAL DIRECTOR Glen Carter Warner E. Humphrey Inc.				25a. REC'D BY REGISTRAR DEC 8 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE HEALTH DEPT

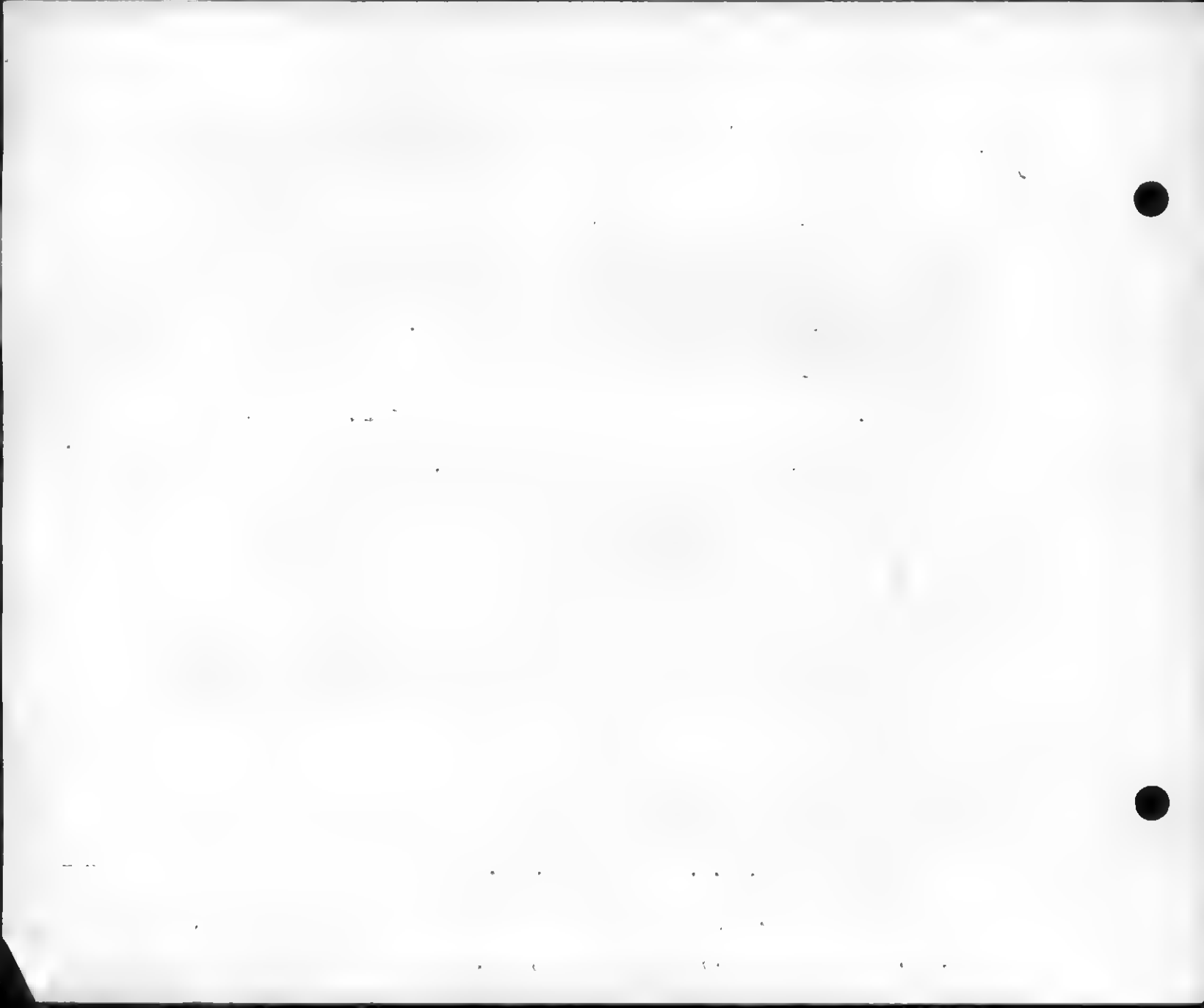
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 243. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kentland		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			d. STREET ADDRESS 2627 Vermont Avenue		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Raymond Middle Todd Last Chippis			4 DATE OF DEATH Month 12 Day 7 Year 19 67		
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11 Sept. 1967	9 AGE (In years last birthday) yrs 2 Months 26 Days 26 Hours Min	IF UNDER 1 YEAR Months 2 Days 26 Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant Child		10b. KIND OF BUSINESS OR INDUSTRY Child		11 BIRTHPLACE (State or foreign country) Maryland	
13 FATHER'S NAME Dale R. Chippis			14 MOTHER'S MAIDEN NAME Doris L. Parish		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO. None		17 INFORMANT Dale R. Chippis, 2627 Vermont Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 7952 IMMEDIATE CAUSE (a) SDII DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SDII DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part II of form 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe		M.D.		22. DATE SIGNED 12-8-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL, (Specify) Burial	23b. DATE THEREOF Dec. 10, 1967	23c. NAME OF CEMETERY Bethel Cemetery	23d. LOCATION (City or Town) (County) (State) Malden, West Virginia		
24 FUNERAL DIRECTOR W. W. CHAMBERS CO.,		Riverdale, Md.		25a. REC'D BY REGISTRAR DATE DEC 12 1967	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

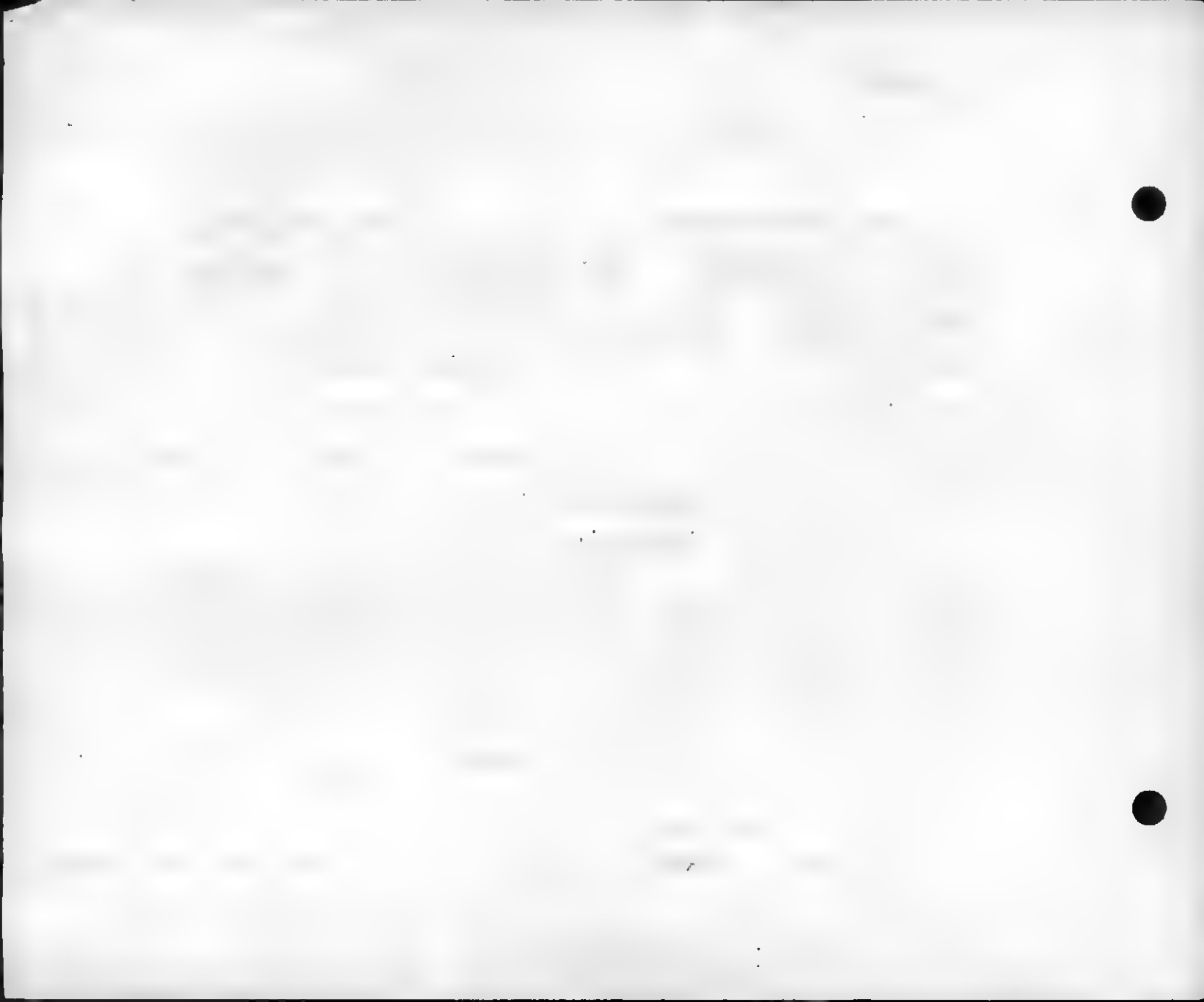
VR A15 (4)
25M 1/67

Item 2 See birth cert. MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11448

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland/ D.C. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews AFB		c. LENGTH OF STAY IN 1b 1 day 10hr	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Malcolm Grow USAF Hosp		d. STREET ADDRESS 338 Marcy Ave Apt 777	
3. NAME OF DECEASED (Type or print) First PATRICIA Middle MARY Last CHRISTIAN		4. DATE OF DEATH Month December Day 15 Year 19 67	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 Dec 67
9. AGE (In years last birthday) 1 yrs		10. IF UNDER 1 YEAR Months 1 Days 10 Hours 38	
11. BIRTHPLACE (County & State or foreign country) Prince George's Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Francis John Christian		14. MOTHER'S MAIDEN NAME Vasilopula Lefter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. na	
17. INFORMANT Father		Address same as item #2	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory distress 173.5 DUE TO immaturity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from 13 Dec , 1967, to 15 Dec , 1967, that (X) (we) last saw the deceased alive on 15 Dec , 1967, and that death occurred at 1120AM from causes and on the date stated above			
22a. SIGNATURE <i>Martin I. Horowitz</i>		22b. DATE SIGNED 15 Dec 67	
22c. PHYSICIAN'S NAME (Type) MARTIN I. HOROWITZ, CAPT		22d. ADDRESS MALCOLM GROW USAF HOSP ANDREWS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 12/19/67	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY ARLINGTON, VIRGINIA	
24. FUNERAL DIRECTOR ROBERT E. WILHELM FUNERAL HOME		25a. REC'D BY REGISTRAR DEC 19 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



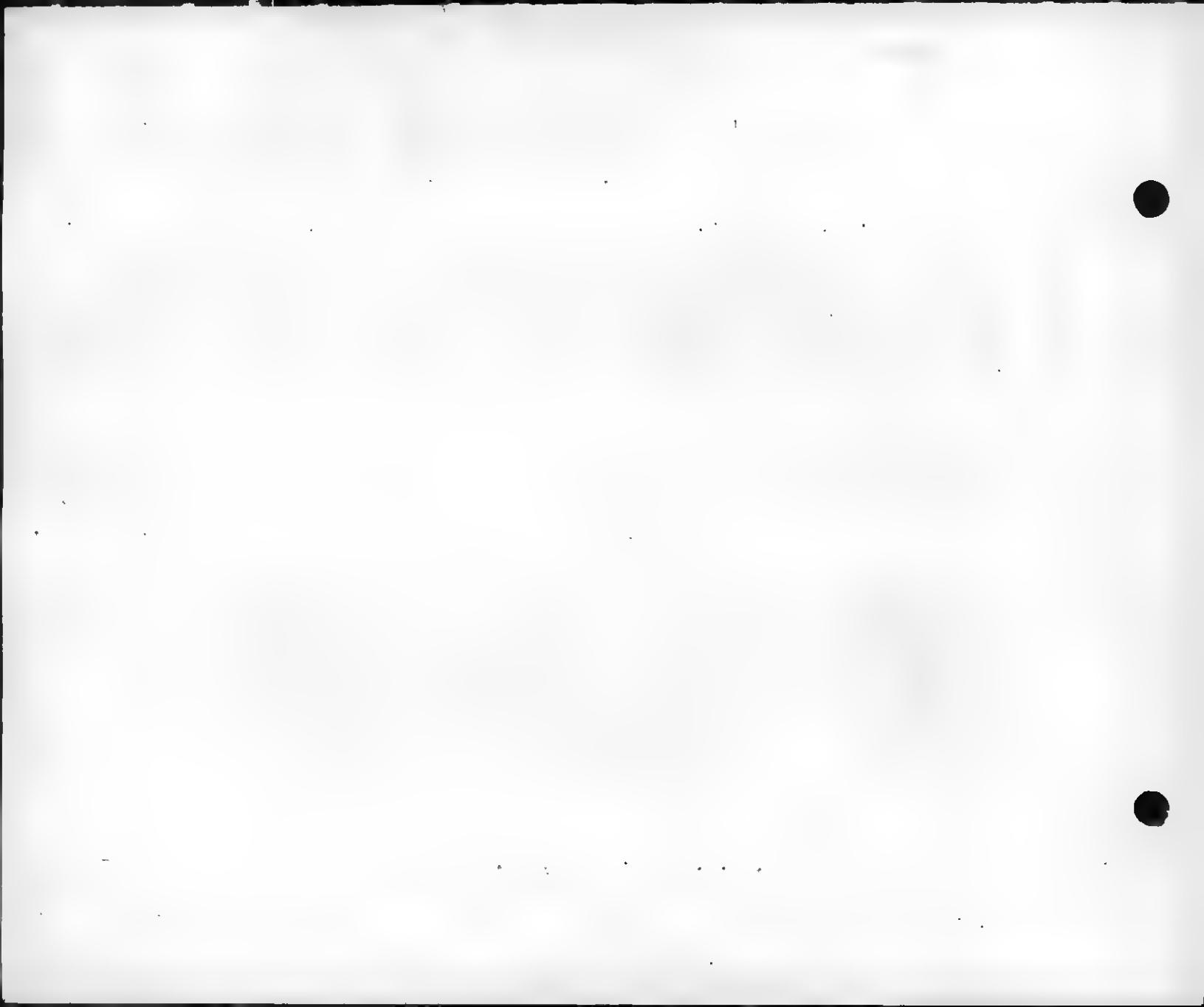
1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11441

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel	
c. LENGTH OF STAY IN 1b 1 hr. 10 min		d. STREET ADDRESS 2301 Joyce Lane	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ieland Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Kermit John Cissell		4. DATE OF DEATH Month Day Year 12 27 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 June 1907
9. AGE (In years last birthday) 60 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) athletic equipment inventory	
11. BIRTHPLACE (State or foreign country) Cannelburg Indiana		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Homer Cissell		14. MOTHER'S MAIDEN NAME Zara Clark	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes 1945-1947		16. SOCIAL SECURITY NO. 219-36-8604	
17. INFORMANT Catherine Cissell-Ahane		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 2 hours over 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 12-27-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 12-29-67	23c. NAME OF CEMETERY OR CREMATORY St. Marys Cem	23d. LOCATION (City, town or county) (State) Laurel Md
24. FUNERAL DIRECTOR Deputy Danielson Laurel Md		25a. REC'D BY REGISTRAR JAN 3 1968	
		25b. REGISTRAR'S SIGNATURE J Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed in 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-5. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

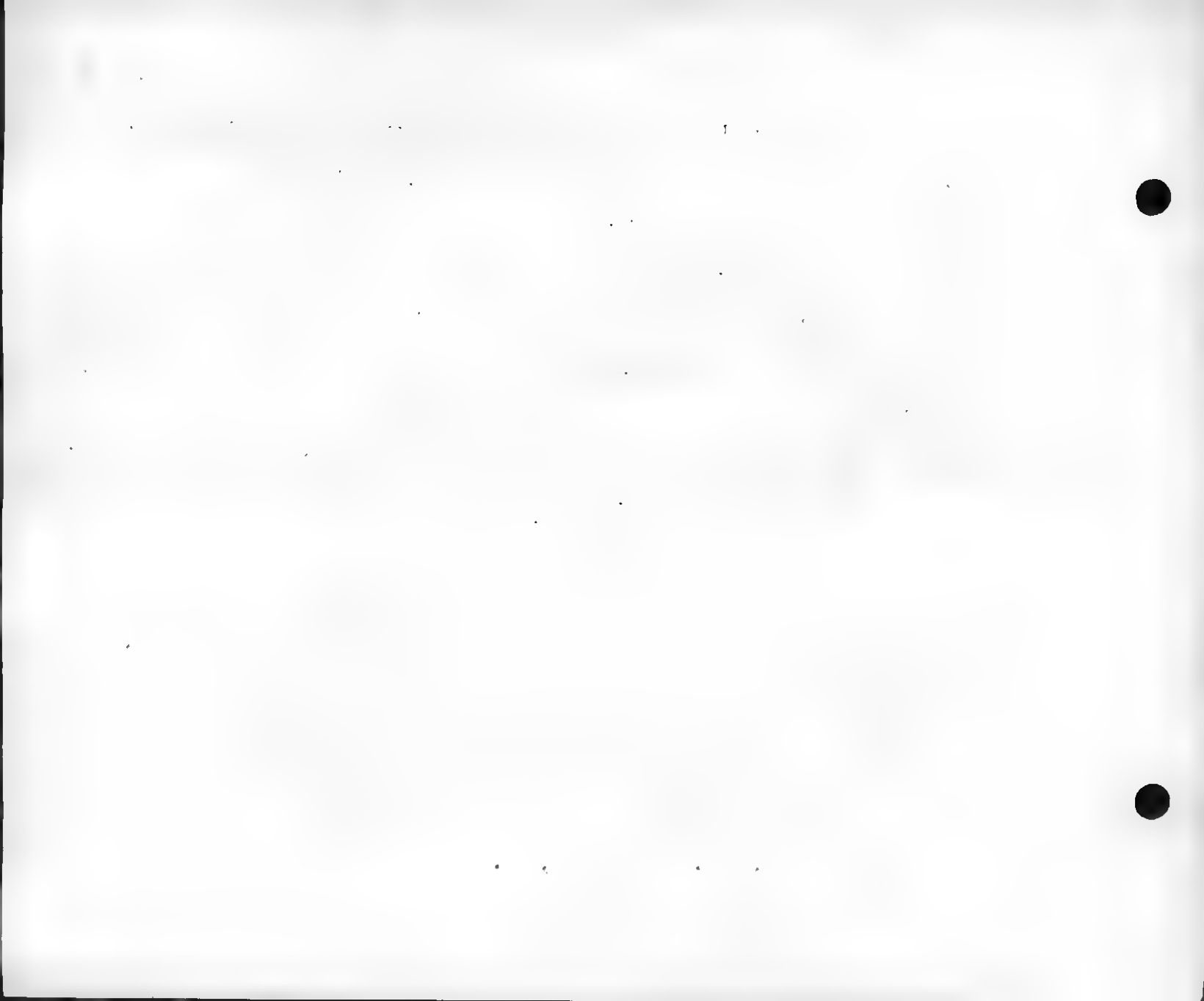
VR A15ME (D)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17450

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN ID DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 1025 Carrington Avenue	
3 NAME OF DECEASED (Type or print) First Richard Middle Clark Last Clark		4 DATE OF DEATH Month 12 Day 13 Year 1967	
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 16 April 1900
9 AGE (In years last birthday) 67 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
10b. KIND OF BUSINESS OR INDUSTRY Government		11 BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Deceased		14 MOTHER'S MAIDEN NAME Deceased	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Bertha Clark - 1025 Carrington Ave - Wife		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH minutes unknown	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 12-14-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-18-67	23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial	23d. LOCATION (City or town) (County) (State) Suitland, Maryland
24. FUNERAL DIRECTOR JOHN T. RHINES FUNERAL HOME 3015 12TH STREET, N.E.		25a. REC'D BY REGISTRAR DEC 18 1967 25b. REGISTRAR'S SIGNATURE W. C. Jones	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

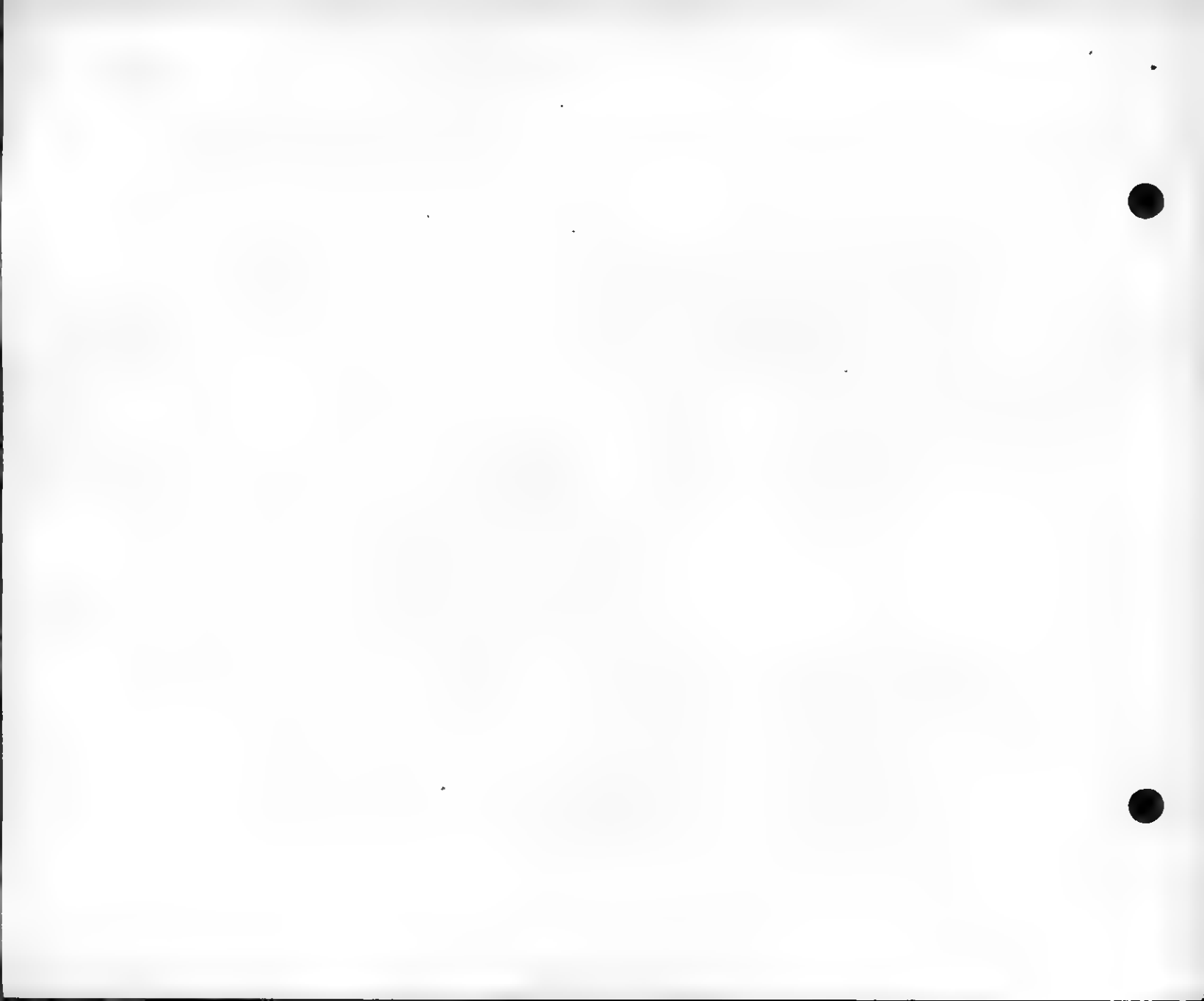
VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17451

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hughesville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pine View Gardens HealthCare Center</u>				d. STREET ADDRESS <u>Hughesville Manor</u>			
3. NAME OF DECEASED (Type or print) First <u>RICHARD</u> Middle <u>Lee</u> Last <u>COCKERILLE</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>9</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>8-6-04</u>	9. AGE (In years last birthday) <u>63</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min <u> </u>	10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Night Clerk in Motel</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MOTEL</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Collington, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Henry Lee Cockerille</u>				14. MOTHER'S MAIDEN NAME <u>Julia Lockwood</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>577-24-989</u>		17. INFORMANT <u>Mrs. Frances Harrison, Hughesville, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>433.0</u> DUE TO <u>Cardiac ARREST</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>PULMONARY EMBOLISM</u> DUE TO <u>ARTERIO SCLEROTIC Cardio Dis.</u> (b) <u> </u> DUE TO <u> </u> (c) <u> </u> DUE TO <u> </u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS A TOLPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/24, 1967</u> to <u>12-9, 1967</u> that (I) (we) last saw the deceased alive on <u>12-9, 1967</u> , and that death occurred at <u>2P</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Alfred R. Lapin, MD</u>				22b. DATE SIGNED <u>12-9-67</u>		22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN, MD</u>	
22d. ADDRESS <u>CLINTON, MD</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>12-13-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	
23d. LOCATION (City or Town) (County) (State) <u>Smithland Pr. Geo. Md.</u>		24. FUNERAL DIRECTOR <u>Home, Waco, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 18 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

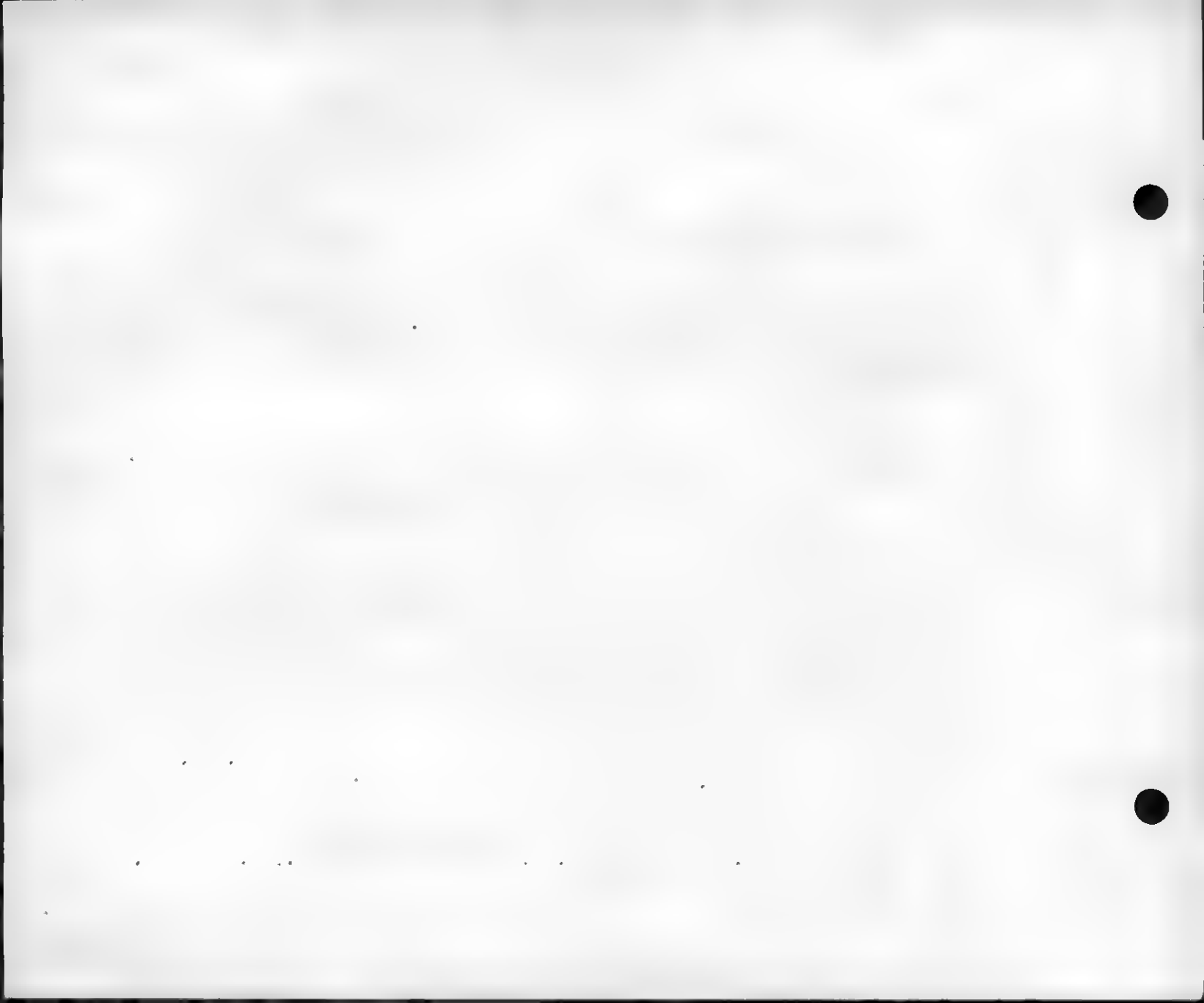
17452

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN 1b 2 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d STREET ADDRESS 6900 Beacon Place	
3. NAME OF DECEASED (Type or print) First Middle Last Cynthia Collihan		4. DATE OF DEATH Month Day Year Dec. 20 19 67	
5. SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 Nov., 1955
9 AGE (In years lost birthday) 12 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY School	
11 BIRTHPLACE (County & State, or foreign country) Washington D. C.		12 C. I. ZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James T Callihan		14. MOTHER'S MAIDEN NAME Margaret V Simmers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO None	
17. INFORMANT James V Simmers		Address Riverdale, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1. Neurocyta etiology undetermined, probably viral DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (NAME) attended the deceased from Dec. 18, 1967 to Dec. 20, 1967 , that (I) (NAME) last saw the deceased alive on Dec. 20, 1967 , and that death occurred at 5.00AM , from causes and on the date stated above			
22a. SIGNATURE Irvin M. Grassgreen, M.D.		22b. DATE SIGNED 12-20-67	
22c. PHYSICIAN'S NAME (Type) Irvin M. Grassgreen, M. D.		22d. ADDRESS 3101 Arundel Rd., Mt. Rainier, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec 23, 1967	23c. NAME OF CEMETERY OR CREMATORY Epiphany Church cemetery	23d. LOCATION (City or Town) (County) (State) Forestville Pro Geo Md.
24 FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. RECEIVED BY REGISTRAR DEC 27 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

This Certificate Examiner notified and approved 12/20/67



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17453

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 15 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5505 40th Avenue		d. STREET ADDRESS 5505 40th Avenue	
3. NAME OF DECEASED (Type or print) ANNA First Middle Last COMISKEY		4. DATE OF DEATH Month Dec. Day 30, Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 8, 1883
9. AGE (In years lost birthday) 84 yrs		10. UNDER 1 YEAR Months 84 Days 0 Hours 0 Min 0	11. UNDER 24 HRS Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Dept. Store	11. BIRTHPLACE (County & State, or foreign country) Indiana
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Patrick Comiskey	
14. MOTHER'S MAIDEN NAME Mary Benson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Cleo M. White Address Same as #2 (Neice)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pneumonia 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic cerebral vascular disease - years DUE TO (c) hypertension			INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 0 m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec 12-27, 1967 , to 12-30, 1967 , that (I) (we) last saw the deceased alive on 12-27, 1967 , and that death occurred at 11:30 p.m. from causes and on the date stated above.			
22a. SIGNATURE Donald C. Edgren M.D.		22b. DATE SIGNED Dec 30, 1967	
22c. PHYSICIAN'S NAME (Type) DONALD C. EDGREN M.D.		22d. ADDRESS Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan 4, 1968	23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Washington D. C.
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville Md.		25a. REC'D BY REGISTRAR JAN 8 1968	25b. REGISTRAR'S SIGNATURE Charles Judge

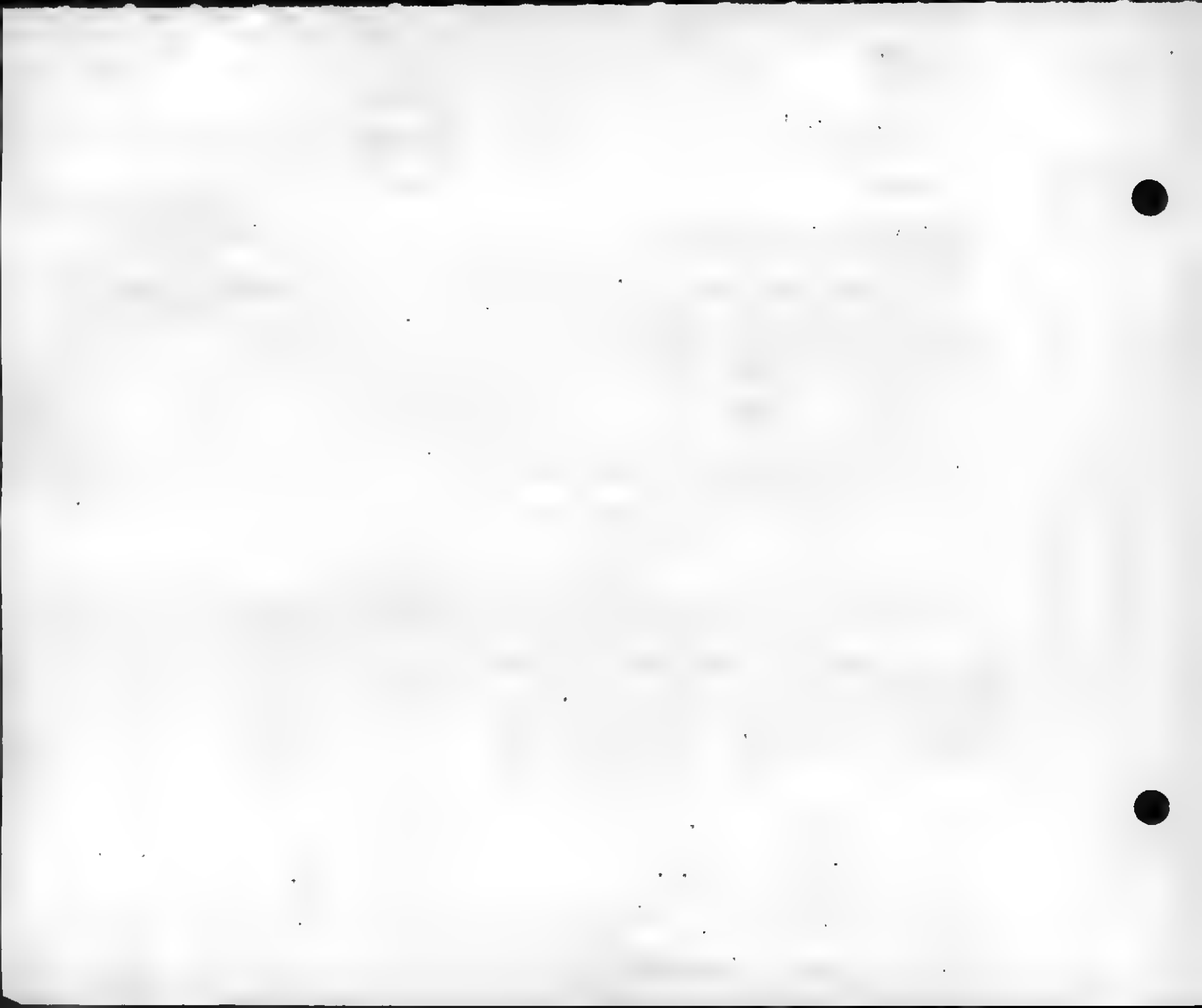


1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100. Page 5, may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours.

1. PLACE OF DEATH a. COUNTY Prince George's				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) b. COUNTY Maryland			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN ID 2 days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's Hospital				e. STREET ADDRESS 9805 Franklin Avenue			
3. NAME OF DECEASED (Type or print) First Middle Last William P. Conboy				4. DATE OF DEATH Month Day Year December 24, 19 67			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 29, 1927	
9. AGE (In years last birthday) 40 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) LONG ISLAND, NEW YORK		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) D.C. FIRE DEPT. (RETIRED)				10b. KIND OF BUSINESS OR INDUSTRY FIREMAN			
13. FATHER'S NAME GEORGE CONBOY				14. MOTHER'S MAIDEN NAME ANNA DE ROE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES W.W. II				16. SOCIAL SECURITY NO. 113 18 9637			
17. INFORMANT MRS ELEANOR E. CONBOY (SAME AS #2)				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of abdomen Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot during altercation			
20c. TIME OF INJURY Month, Day, Year 11 PM a.m. 12/22 1967				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) See 2				(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe, M.D.				22. DATE SIGNED 12-26-67			
EXAMINER'S NAME (Type)				Address (City, town or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 28, 1967		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town or county) (State) Baltimore MD	
24. FUNERAL DIRECTOR John Kehoe, M.D.				25a. REC'D BY REGISTRAR DATE DEC 29 1967			
ADDRESS				25b. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

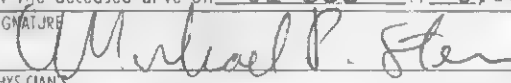

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landonover Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landonover</u> Apt # 304 16-1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3400 Large Lake Road</u>		d. STREET ADDRESS <u>3408 Dodge PK Rd</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Louise Mary Cook</u>		4. DATE OF DEATH Month Day Year <u>Dec. 13, 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/31/1888</u>
9. AGE (In years last birthday) <u>78</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John Rogers</u>		14. MOTHER'S MAIDEN NAME <u>Margaret S.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Harry J. Marino</u>		Address <u>Landonover, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility</u> DUE TO (c) <u>Senility</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C. U. D. —</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> to <u>Dec 13, 1967</u> that (I) <u>last</u> saw the deceased alive on <u>12-12-1967</u> and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Bernard Kutzan</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>BERNARD KATZMAN MD</u>		22d. ADDRESS <u>2645 - Naylor Rd. S.E. Wash. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec 16, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 18 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1456

1 PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND b. CITY OR TOWN (If outside corporate limits, write R.R. and give nearest town) ANDREWS AFB c. LENGTH OF STAY IN 1b 1 Hr d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MALCOLM GROW USAF HOSP				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE D.C. b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON d. STREET ADDRESS 2102 Savannah Terrace e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last WILLIAM JACKSON COOPER			4. DATE OF DEATH Month Day Year December 31 19 67				
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 21 Nov 34	9 AGE (in years last birthday) yrs 33	10 UNDER 1 YEAR Months Days Hours Min 33		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Computer Programmer		10b. KIND OF BUSINESS OR INDUSTRY Computer Programmer		11 BIRTHPLACE (County & State or foreign country) Maryland			
13 FATHER'S NAME WARDELL RAINEY COOPER			14. MOTHER'S MAIDEN NAME EDNA COOPER(WIFE) Same As #2				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1958-67		16. SOCIAL SECURITY NO. 212-325-101		17. INFORMANT Address EDNA COOPER(WIFE) Same As #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation DUE TO (b) Acute Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) _____					INTERVAL BETWEEN ONSET AND DEATH 50 Min. 1 day		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II. of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) 20f. (City or town) (County) (State)							
21 I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 30 Dec , 19 67 , to 31 Dec , 19 67 , that (I) (we) last saw the deceased alive on 31 Dec , 19 67 and that death occurred at 12:18 AM on causes and on the date stated above							
22a. SIGNATURE  M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) MICHAEL P. STERN, CAPT, USAF MALCOLM GROW USAF HOSP AAFB 22d. ADDRESS					22b. DATE SIGNED		
23a. BURIAL, CREMATION REMOVAL (Specify) 115-168		23b. DATE THEREOF 115-168		23c. NAME OF CEMETERY OR CREMATORY Arlington National			
24. FUNERAL DIRECTOR ROBERT G. MASON FUNERAL HOME, INC. 2500 NICHOLS AVENUE, S.E.		25a. REC'D BY REGISTRAR OATE JAN 5 1968		25b. REGISTRAR'S SIGNATURE 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, with in 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

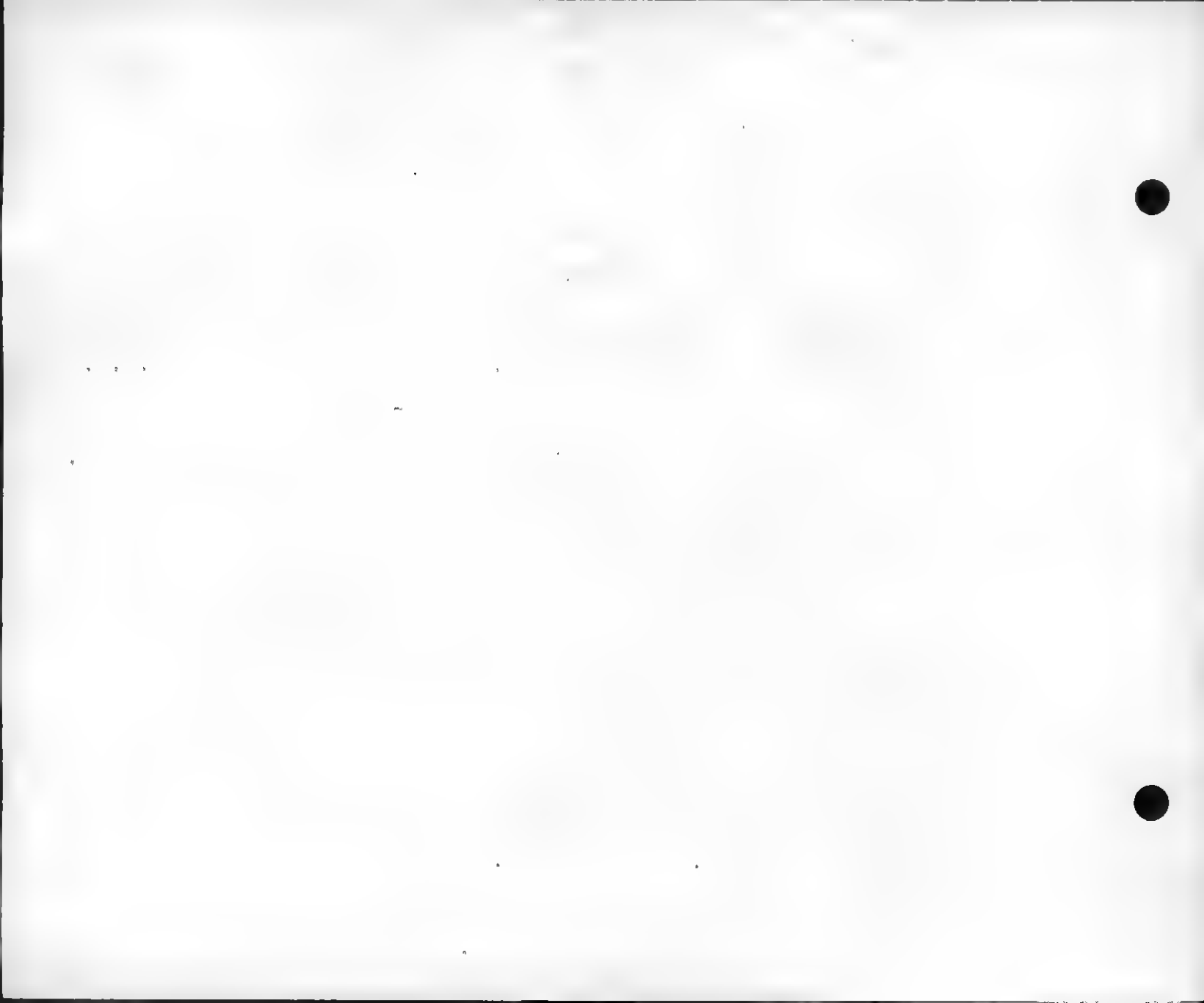
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11457

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived) f. Institution Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Suitland</u>		c. LENGTH OF STAY In 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Andrew's Air Force Base Hospital</u>		d. STREET ADDRESS <u>Box 23</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Martin Van Cox</u>		4. DATE OF DEATH Month Day Year <u>12 4 19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-5-1916</u>
9. AGE (In years last birthday) <u>51</u> yrs		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Parker Door Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Van Cox</u>		14. MOTHER'S MAIDEN NAME <u>Ava Minney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>235 16 6276</u>	
17. INFORMANT <u>Dorothy Cox</u>		Address <u>Glenville, W.Va.</u>	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.		22. DATE SIGNED <u>12-4-67</u>	
EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county)	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-7-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Normantown, W.Va.</u>
24. FUNERAL DIRECTOR <u>Nalley Funeral Home Mt Rainier, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 7 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

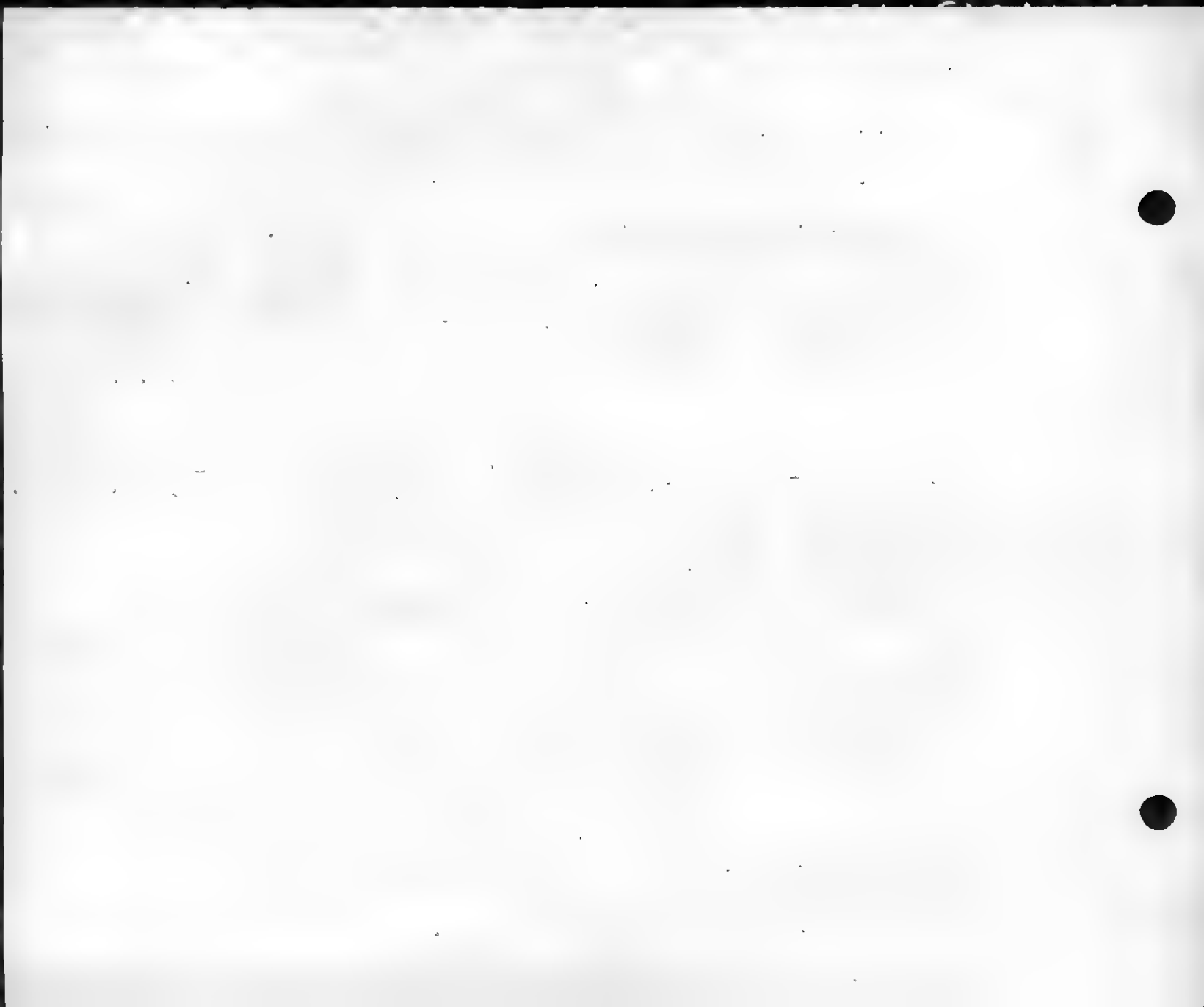
17455

17458

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d STREET ADDRESS 4011 Utah Ave.	
3 NAME OF DECEASED (Type or print) First Bessie Middle M. Last Cralle		4 DATE OF DEATH Month Dec. Day 11 Year 19 67	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-6-79
9. AGE (In years last birthday) yrs. 88		10. IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b KIND OF BUSINESS OR INDUSTRY Secretary	
11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Grimes		14. MOTHER'S MAIDEN NAME Elizabeth Scott	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 212-01-2965	
17 INFORMANT (Daughter) Mrs. Trueheart Lindley - Orchard Rd.		Address 15210-Peach	
18 CAUSE OF DEATH (Enter only one cause per line, and in order of sequence) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE 1. DISEASED LEFT VENTRICLE (POSTERIOR WALL) infarcted 2. ACUTE MYOCARDIAL INFARCTION 3. ACUTE THROMBOSIS of RT. CORONARY ARTERY 4. Hypertensive Arterio-sclerotic disease 5. Pulmonary thromboembolism-LEFT LUNG		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec. 2 , 1967, to Dec. 11 , 1967, that (I) (we) last saw the deceased alive on Dec. 11 , 1967, and that death occurred at 7:00 P.M. , from causes and on the date stated above			
22a SIGNATURE Charles C. Hageage		22b DATE SIGNED	
22c PHYSICIAN'S NAME (Type) Charles C. Hageage		22d ADDRESS 3368 Proxy St. Mt. Rainier, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/13/67	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24 FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25a. REC'D BY REGISTRAR OATE DEC 18 1967	
ADDRESS Mt. Rainier, Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 6102 Kolb Street	
3. NAME OF DECEASED (Type or print) First Eldora Middle Crayton Last Crayton		4. DATE OF DEATH Month 12 Day 15 Year 1967	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1898-
9. AGE (In years last birthday) yrs 69		10. FUND 1 YEAR Months 12 Days 15 Hours 19 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown - Re		14. MOTHER'S MAIDEN NAME Unknown Robbins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO None	
17. INFORMANT Phillip Crayton		Address Richmond VA	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation 716.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Burns, 50% of body surface DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) trapped in house fire			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) trapped in house fire	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 1:45 p.m. 12-15 1967		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) same as #2	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect an <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 12-15-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) 12-20-67		23b. DATE THEREOF CARVER	
23c. NAME OF CEMETERY OR CREMATORY H.S. Washington & Sons 4925 Deane Ave NE		23d. LOCATION (City or Town) (County) (State) Murkink Md	
24. FUNERAL DIRECTOR H.S. Washington & Sons 4925 Deane Ave NE		25a. REC'D BY REGISTRAR DEC 21 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

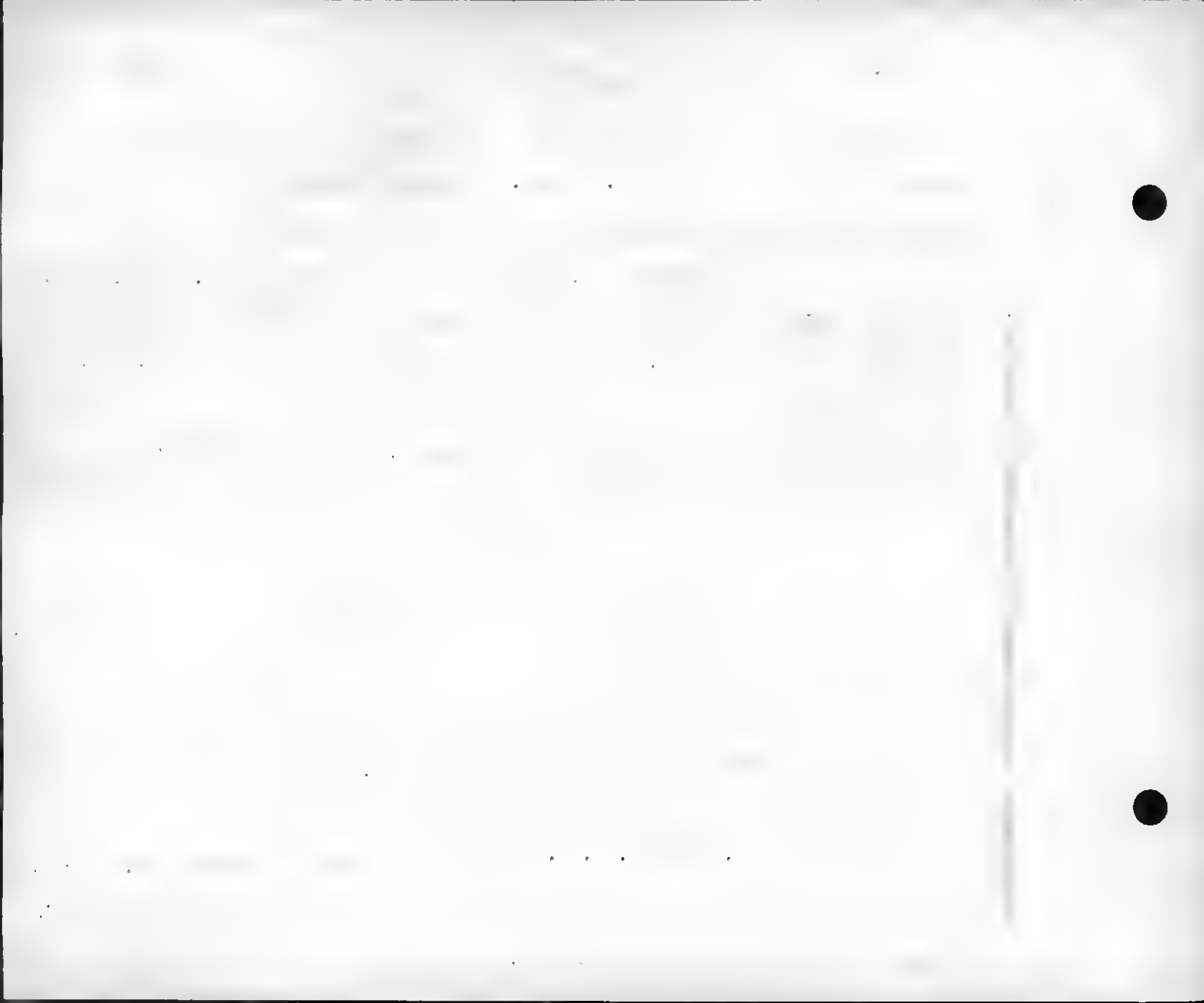
CERTIFICATE OF DEATH

1457

1460

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 0hrs. 50 mins.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 4121 Fairfax Street			
3. NAME OF DECEASED (Type or print) Robert William Cronin				4. DATE OF DEATH Dec. 22, 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 18, 1900	
9. AGE 'In years last birthday) 67 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		11. BIRTHPLACE (County & State, or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Francis Cronin				14. MOTHER'S MAIDEN NAME Mary Hickey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 214 12 4351A		17. INFORMANT Same as #2 Maureen T. Dudley Daughter			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema & vascular congestion DUE TO Widespread metastases to lung & bone CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), (b) 1810 losing the underlying cause lost. (c) Carcinoma of urinary bladder							INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 1 year 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (as a doctor) attended the deceased from June, 1967 to Dec, 1967 , that (I) (as a) last saw the deceased alive on Dec 21, 1967 , and that death occurred at 1:50 A M, from causes and on the date stated above.							
22a. SIGNATURE Thomas G. Maloney M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 21 Dec 67	
22c. PHYSICIAN'S NAME (Type) Thomas G. Maloney, M. D.				22d. ADDRESS 4814 71st Avenue, Landover Hills, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/26/67		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City or Town) (County) (State) Silver Spring Montg., Md.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR DEC 28 1967		25b. REGISTRAR'S SIGNATURE [Signature]	



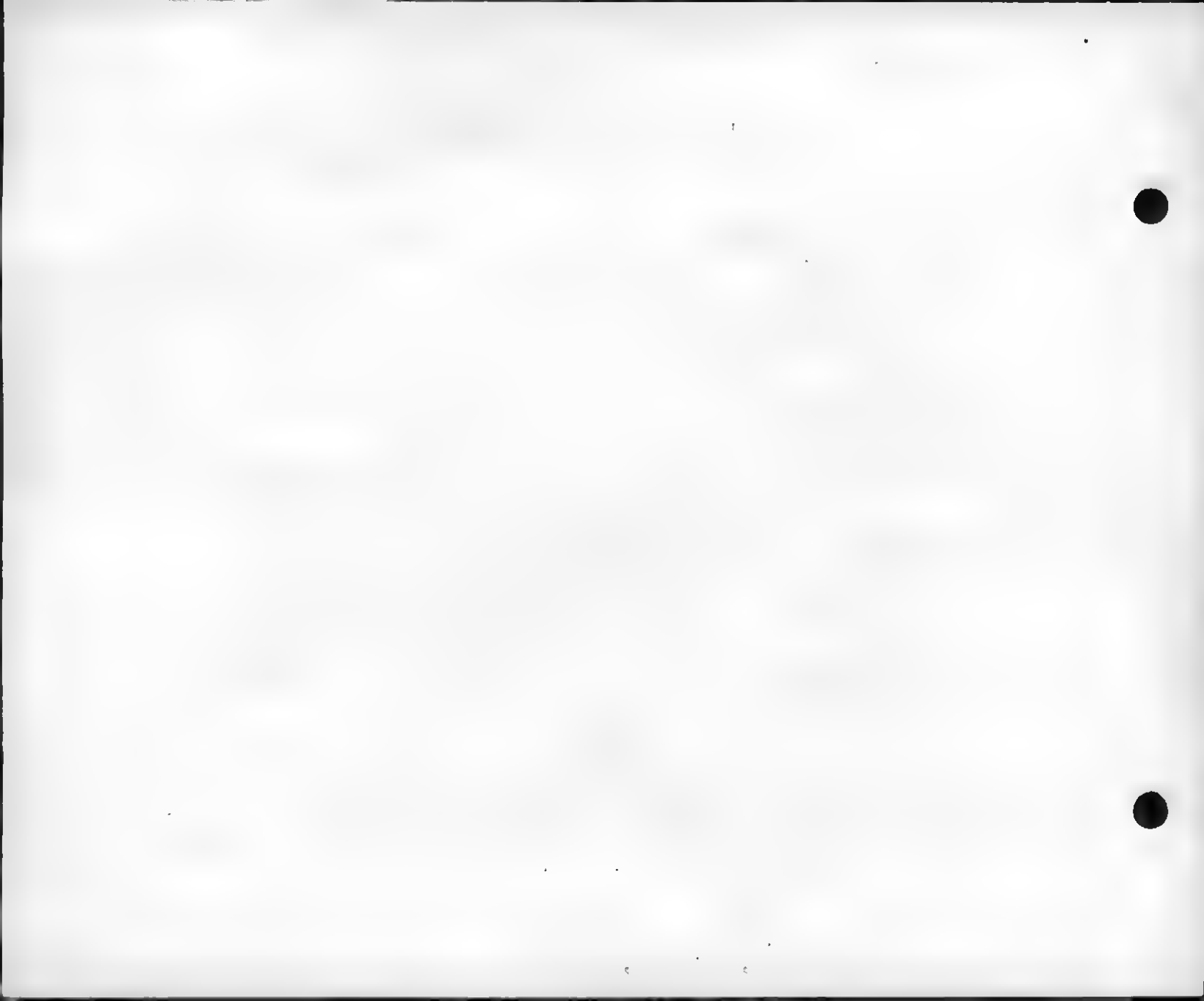
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY PRINCE GEORGE'S MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE MARYLAND b COUNTY PRINCE GEORGE'S	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE		c LENGTH OF STAY in 1b 43 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS		d STREET ADDRESS 1916 CALLAWAY	
3 NAME OF DECEASED (Type or print) ALICIA MAY CROSSMAN		4 DATE OF DEATH Month DECEMBER Day 16 Year 19 67	
5 SEX FEMALE	6 COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2 MAR 1961
9 AGE (In years lost birthday) 6 yrs.		11. BIRTHPLACE (County & State or foreign country) FLORIDA	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXXXXXXXX		10b KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME JERRY MILTON CROSSMAN		14. MOTHER'S MAIDEN NAME BETTY MARIE ALLEN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT FATHER		Address SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Probable Intra-aortic Hemorrhage 204.3 DUE TO Probable from Negative Sepsis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Acute Leukemia (c)		INTERVAL BETWEEN ONSET AND DEATH 15 mo.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 25 AUG. 19 67 to 16 Dec. 1967 , that (I) (we) last saw the deceased alive on 16 Dec. 19 67 and that death occurred at 3:15 PM , from causes and on the date stated above			
22a SIGNATURE W. F. Burger		22b DATE SIGNED 16 Dec 1967	
22c PHYSICIAN'S NAME (Type) WILBUR BURGER, CAPT, USAF, MC		22d ADDRESS USAF HOSPITAL ANDREWS ANDREWS AFB, WASHINGTON DC 20331	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 12/20/67	23c NAME OF CEMETERY OR CREMATORY Arlington National Cemetery Arlington, Virginia	23d LOCATION (City or town) (County) (State)
24 FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home		25a REC'D BY REGISTRAR DEC 21 1967	
4308 Suitland Road, Suitland, Maryland		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (one-27) and depth. should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

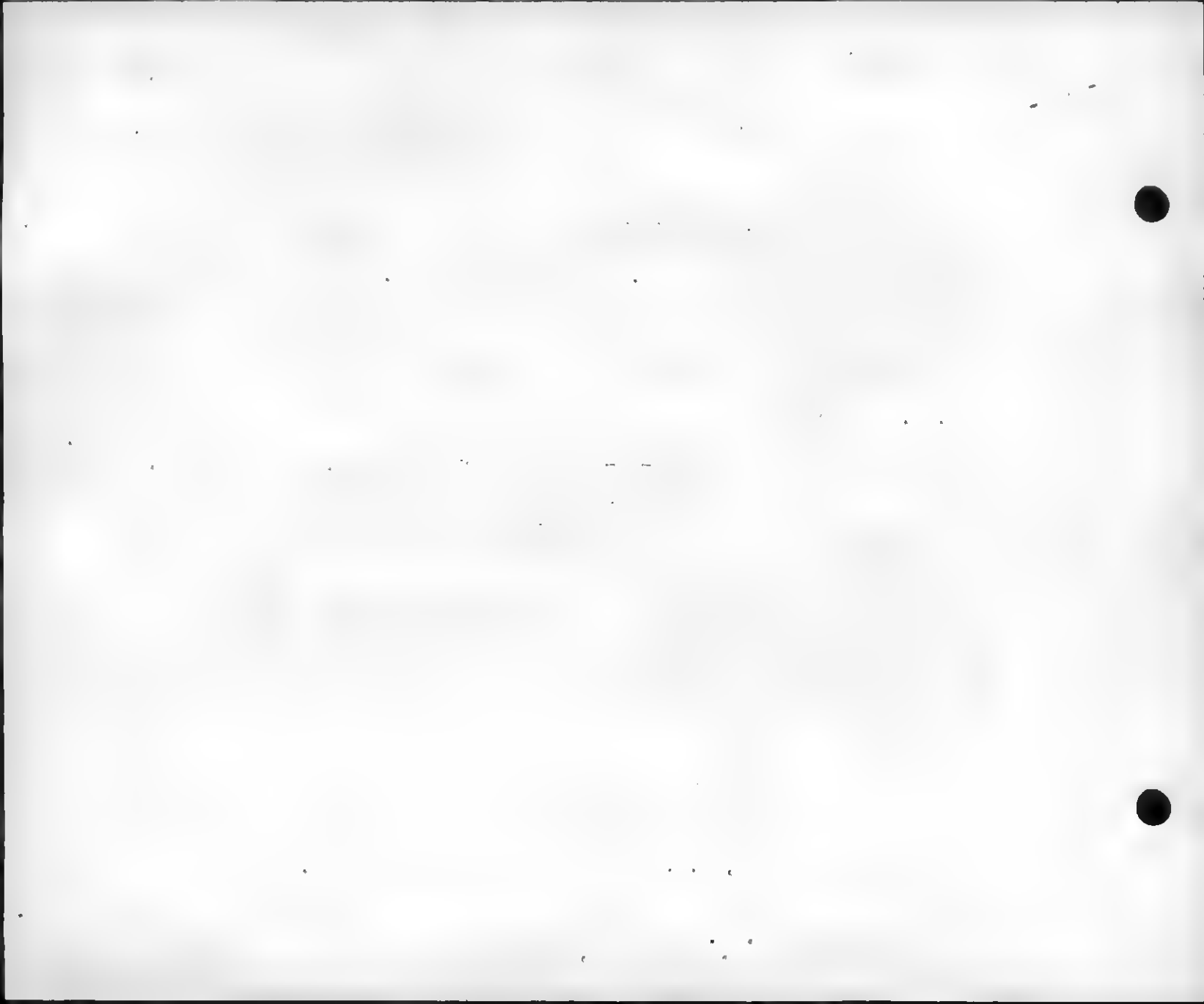
17459

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17462

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park		d. STREET ADDRESS 5902 Berwyn Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Richard H. Crummett Sr.		4. DATE OF DEATH Month Day Year 12 14 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 August 1887
9. AGE (In years last birthday) 80 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME S. W. Crummett		14. MOTHER'S MAIDEN NAME Sally Harding	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 230-48-6869	
17. INFORMANT Address Park, Md.		18. Catherine Harper, 5902 Berwyn Rd., College	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH over 5 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from December, 1963 to 12-13-1967 , that (I) (we) last saw the deceased alive on 12-13-1967 , and that death occurred at 3:00am from causes and on the date stated above			
22a. SIGNATURE John Kehoe, M.D.		22b. DATE SIGNED 12-14-67	
22c. PHYSICIAN'S NAME (Type) John Kehoe, M.D.		22d. ADDRESS Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/18/67	23c. NAME OF CEMETERY OR CREMATORY Blue Grass	23d. LOCATION (City or town) (County) (State) Blue Grass Highland Va.
24. FUNERAL DIRECTOR Wheeler F. H. 1331 Rockville Pk. Rockville, Maryland		25a. REC'D BY REGISTRAR DEC 21 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL EXAMINER NOTIFIED AND APPROVED THIS CERTIFICATE ISSUE

CERTIFICATE OF DEATH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 DECEASED NAME (Type or print) Katherine Marjorie Daly			First Middle Last			2a DATE OF DEATH Month Dec Day 10 Year 1967			2b HOUR 1030A					
3 SEX F			4 RACE Caucasian			5. DATE OF BIRTH 12-7-28			6 AGE (In years last birthday) 39 YRS			7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country) D.C.			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George's Md.					
10 CITY OR TOWN OF DEATH Greenbelt, Md			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greenbelt Corral Center			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) none			12b KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md			13b. COUNTY MD			13c CITY OR TOWN MD			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 4518 Harling Lane		
14 FATHER'S NAME First Middle Last John J. DALY			15. MOTHER'S MAIDEN NAME First Middle Last J. Katherine Taylor			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (if yes give war or dates of service) None			16b SOCIAL SECURITY NO. None			17 INFORMANT Address John J. DALY, Bethesda, Maryland		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Grand Mal Seizure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DO TO, OR AS A CONSEQUENCE OF (b) epilepsy										years				
DO TO, OR AS A CONSEQUENCE OF (c) mental retardation (birth defect)										life				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION none			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED none			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from Nov 17, 1967 to Dec 10, 1967 , that (I) (we) last saw the deceased alive on Nov 30, 1967 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b SIGNATURE Burton H. Johnson MD DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>										22c DATE SIGNED Dec 16, 1967				
22d. PHYSICIAN'S NAME (Type) Burton H. Johnson						22e ADDRESS 11358 Cherry Hill Rd, Beltsville, Md.								
23a. BURIAL, CREMATION, or other disposition (Specify) BURIAL			23b. DATE 14Dec1967			23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.			23d. LOCATION (City or Town) (County) (State) Salver Spring, Maryland					
24. FUNERAL DIRECTOR ADDRESS Robert A. Pumphrey Bethesda, Md.						25a. REC'D BY REGISTRAR DATE DEC 15 1967			25b. REGISTRAR'S SIGNATURE Charles Judge					



VR A15 (4)
25M 1/67



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

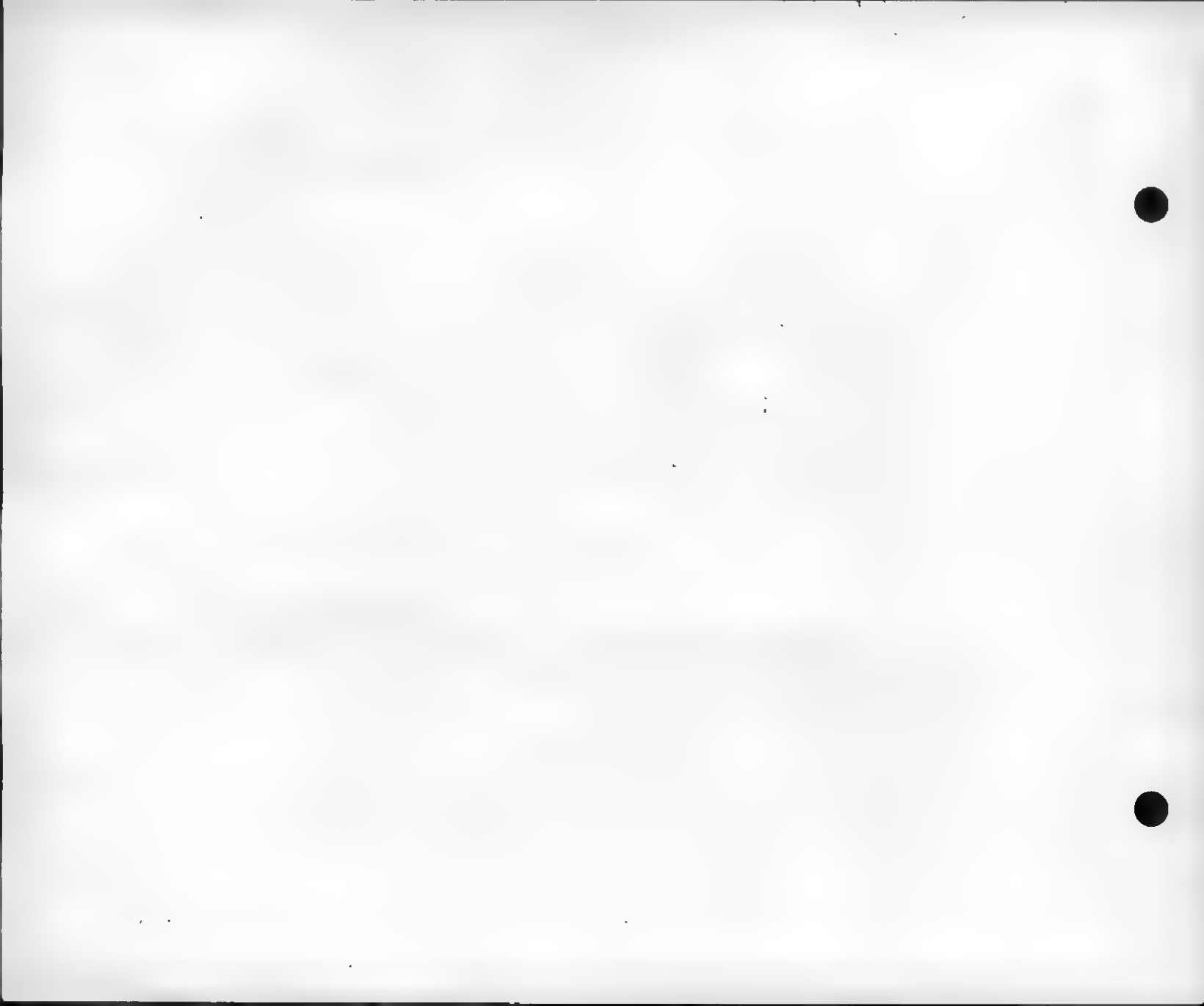


4 1
622
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17465

1. PLACE OF DEATH a. COUNTY <u>Pr. George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a. STATE <u>MD</u> b. COUNTY <u>Pr Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY in 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pr. Geo. Gen'l Hosp.</u>		d. STREET ADDRESS <u>6605 DREIG ST.</u>	
3. NAME OF DECEASED (Type or print) <u>WALTER Wellington DEARBORN</u>		4. DATE OF DEATH Month <u>12</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 13, 1908</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAIL CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. POST OFFICE DEPT. MICHIGAN</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. C.T. ZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Henry Dearborn</u>		14. MOTHER'S MAIDEN NAME <u>Ida Dewey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>213-16-2210</u>	
17. INFORMANT <u>MRS FLORENCE DEARBORN</u>		Address <u>6605 GRIEG ST. SEAT PLEASANT, MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO <u>arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Tuberculosis</u> (c) <u>myocardial infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>old healed tuberculosis & left heart coronary</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 1966</u> , 1966, to <u>Dec 2</u> , 1967, that (I) (we) last saw the deceased alive on <u>12/2</u> 1967, and that death occurred at <u>1:30</u> P.M. from causes and on the date stated above			
22a. SIGNATURE <u>Tie Bergemann</u>		22b. DATE SIGNED <u>12-3-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>TIE BERGEMANN M.D.</u>		22d. ADDRESS <u>Prinice Huges the Hosp Chevy Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>DEC. 6, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>BLADENSBURG MD.</u>	
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS CO. 517 11th St. S.E. Wash. D.C.</u>		25a. REC'D BY REGISTRAR <u>DEC 7 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



FOR STATE
HEALTH DEPT.

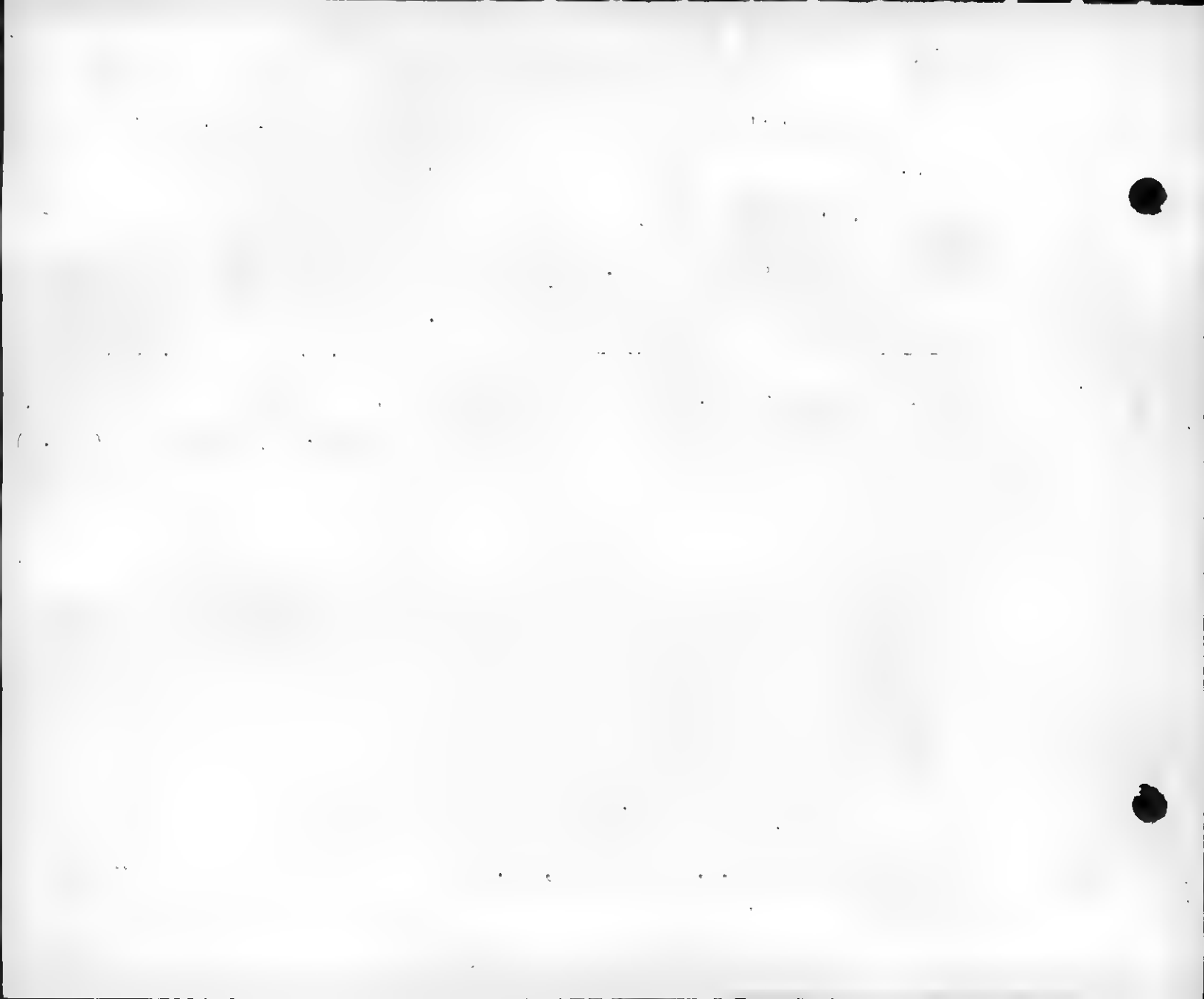
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1463

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1.466

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>	
c. LENGTH OF STAY IN 1b <u>DOA</u>		d. STREET ADDRESS <u>5309 Riverdale Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Anthony A. DeMarco</u>	First Middle Last	4. DATE OF DEATH <u>12 21 1967</u>	Month Day Year
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>30 Sept. 1965</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____		9. AGE (In years last birthday) <u>2</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Washington D. C.</u>	
13. FATHER'S NAME <u>Anthony A. DeMarco Jr.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Anthony A. DeMarco Jr. Same as #2 (father)</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute laryngo tracheo bronchitis</u> <u>501X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.		22. DATE SIGNED <u>12-21-67</u>	
EXAMINER'S NAME (Type) <u>John Kehoe, M.D.</u>		Address (Street, city, town, or county) <u>Riverdale, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/23/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	23d. LOCATION (City, town or county) (State) <u>Washington D. C.</u>
24. FUNERAL DIRECTOR <u>Francis Gasch's Sons</u>		25a. REC'D BY REGISTRAR <u>DEC 28 1967</u>	
ADDRESS <u>Hyattsville, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



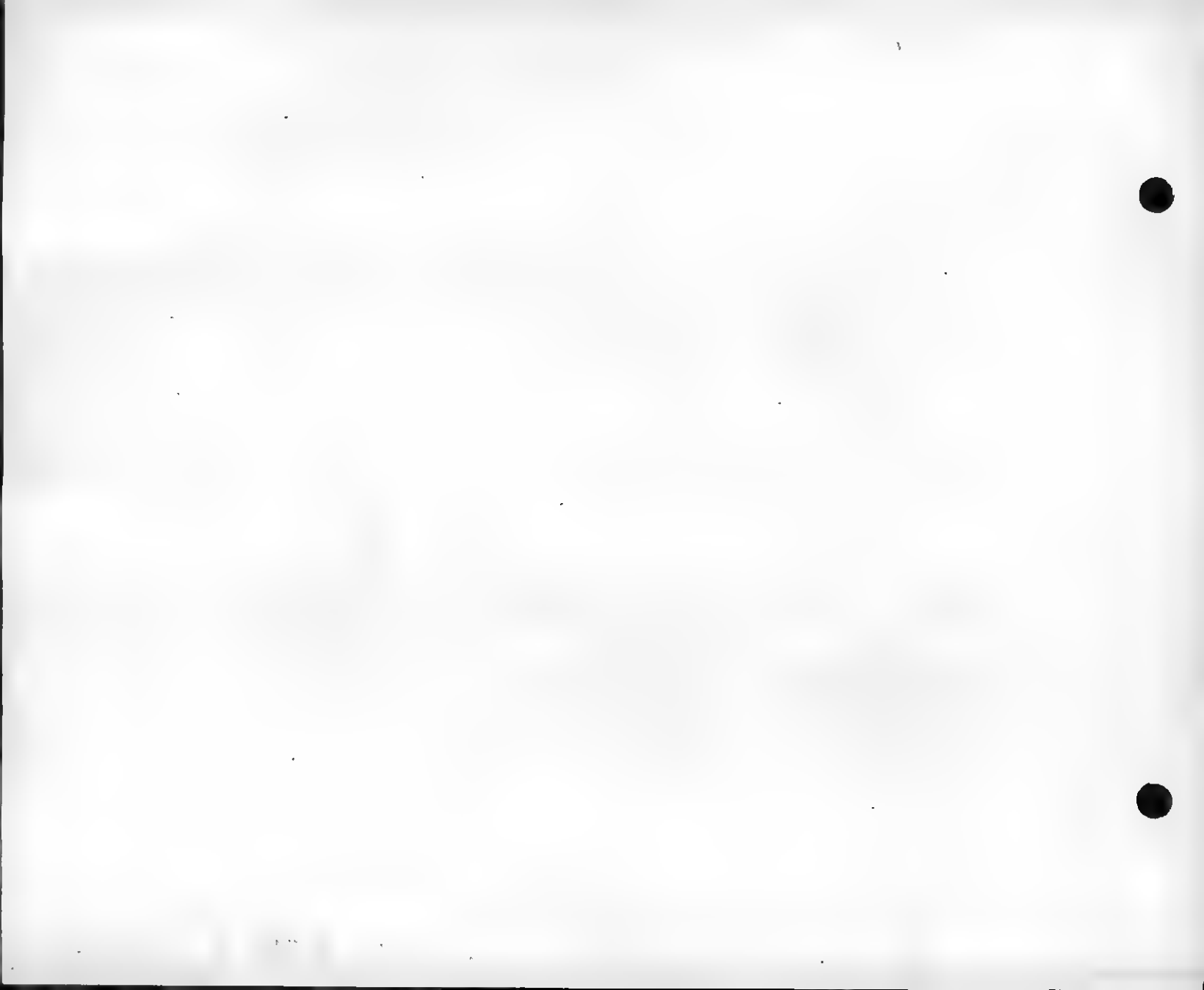
CERTIFICATE OF DEATH

11467

1 PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Croft</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 months</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Croft Convalescent Center</u>		d. STREET ADDRESS <u>Box 167</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Helen M. Donaldson</u>		4 DATE OF DEATH Month Day Year <u>December 23 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4-4-02</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>OSCAR JACKSON</u>		14. MOTHER'S MAIDEN NAME <u>Emma Fenton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>320-560688</u>	
17. INFORMANT <u>Jean Livingston</u> Address <u>Croft Convalescent Center</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple metastases of</u> DUE TO <u>Leipomyo sarcoma to multiple</u> (b) <u>abdominal viscera</u> DUE TO <u>Primary Leipomyo sarcoma of</u> (c) <u>stomach - hysterectomy Oct 1962</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u> <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1</u> , 1962, to <u>Dec 23</u> , 1967, that (I) (we) last saw the deceased alive on <u>Dec 21</u> , 1967, and that death occurred at <u>8 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>George L. Ball</u> M.D.		22b. DATE SIGNED <u>Dec 23, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>George L. Ball</u>		22d. ADDRESS <u>10620 Georgetown Rd. Silver Spring, Md. 20902</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-27-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR <u>Joseph E. Burden</u> ADDRESS <u>Washington D.C.</u>		25a. REC'D BY REGISTRAR <u>3 1968</u> DATE <u>Jan 3 1968</u>	
		25b. REGISTRAR'S SIGNATURE <u>John Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

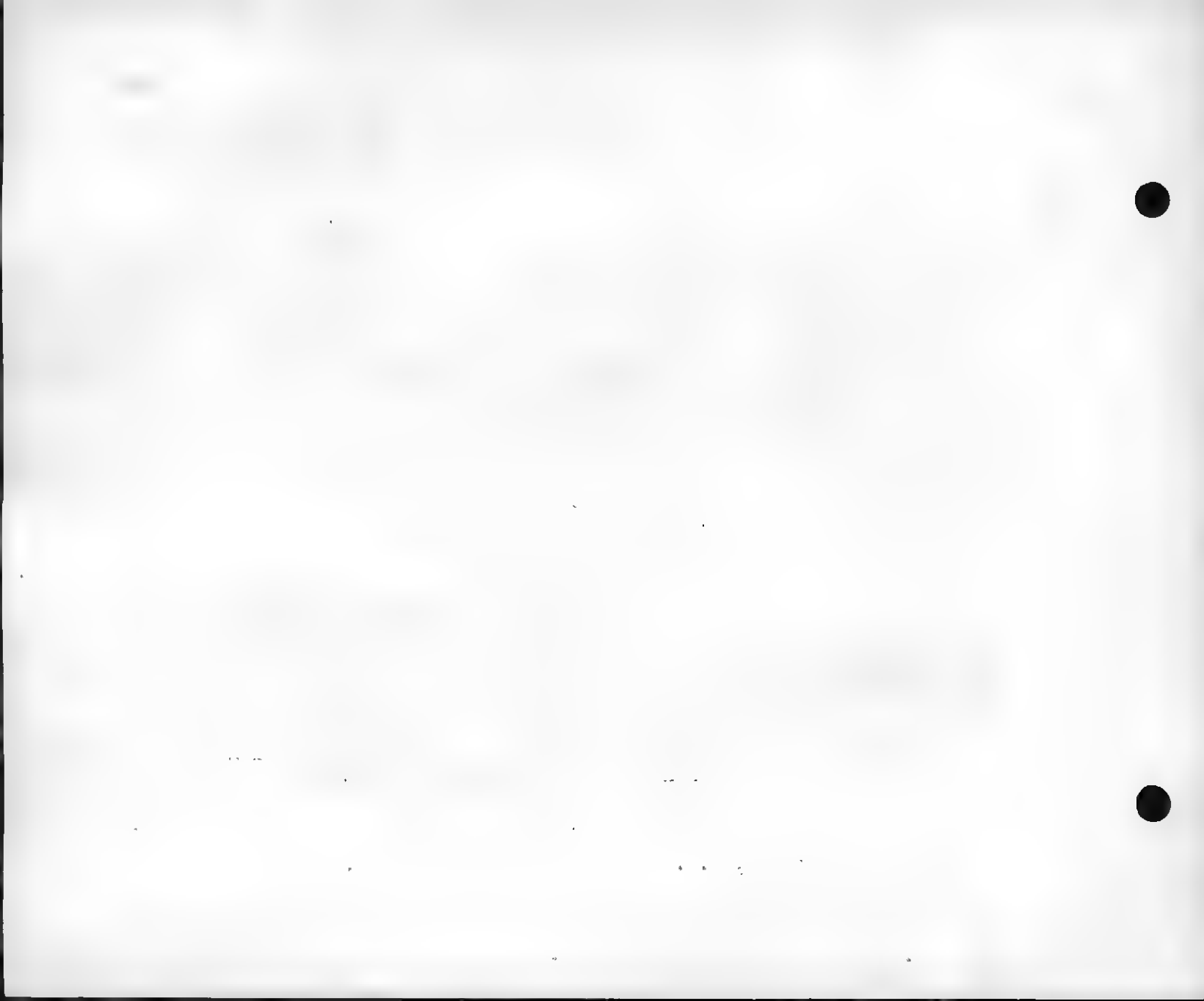
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Pro Geo MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md b. COUNTY Pro Geo	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pro Georges General Hospital		d. STREET ADDRESS 3713 41th ave	
3 NAME OF DECEASED (Type or print) First Raleigh A Middle Donley Last Sr		4. DATE OF DEATH Month Dec Day 5 Year 19 67	
5 SEX male	6. COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 27, 1894
9 AGE (in years last birthday) yrs 73		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printing		10b. KIND OF BUSINESS OR INDUSTRY Self employed	
11. BIRTHPLACE (County & State, or foreign country) West Va		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Wm C Donley		14. MOTHER'S MAIDEN NAME Margaret Knott	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO 579 05 9057	
17. INFORMANT Raleigh A Donley Jr, Cottage City, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 420.0 DUE TO Arteriosclerotic heart disease (b) And Pulmonary failure DUE TO Pulmonary emphysema (c) 		INTERVAL BETWEEN ONSET AND DEATH minutes over 5 yrs 2 years over 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) 420.0		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April , 19 61 , to 12-4- , 19 67 , that (I) (we) last saw the deceased alive on 12-4-67 , and that death occurred at 10:35 AM from causes and on the date stated above.			
22a. SIGNATURE John Kehoe M.D.		22b. DATE SIGNED 12-6-67	
22c. PHYSICIAN'S NAME (Type) John Kehoe, M.D.		22d. ADDRESS Riverdale, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec 8, 1967	23c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery	23d. LOCATION (City or Town) (County) (State) Sheppard Town West Va
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DEC 11 1967	
25b. REGISTRAR'S SIGNATURE f. Charles Judge			



FOR STATE
HEALTH DEPT.

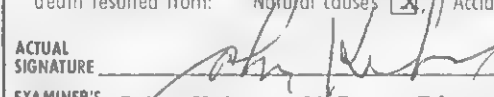

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY in lb DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marlowe Heights			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 2900 St. Clair Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Maranda Middle E Last Driscoll				4. DATE OF DEATH Month XII Day 12 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 Aug. 1892		9. AGE (In years last birthday) 75	F UNDER 1 YEAR Months 12 Days 14 HOURS 19 MIN 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Hungerman				14. MOTHER'S MAIDEN NAME Clara Holmes			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO		17. INFORMANT James B. Driscoll		Address Same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Hypertensive cardio vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) over 5 yrs.						INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item B)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) John Kehoe, M.D.				22. DATE SIGNED 12-15-67			
23a. BURIAL, CREMATION, or DISPOSAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		Dec. 18-67		Cedar Hill Cemetery		Suitland, Maryland	
24. FUNERAL DIRECTOR Simmons Bros.				ADDRESS Wash., DC		25a. REC'D BY REGISTRAR DEC 19 1967	
				25b. REGISTRAR'S SIGNATURE 			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

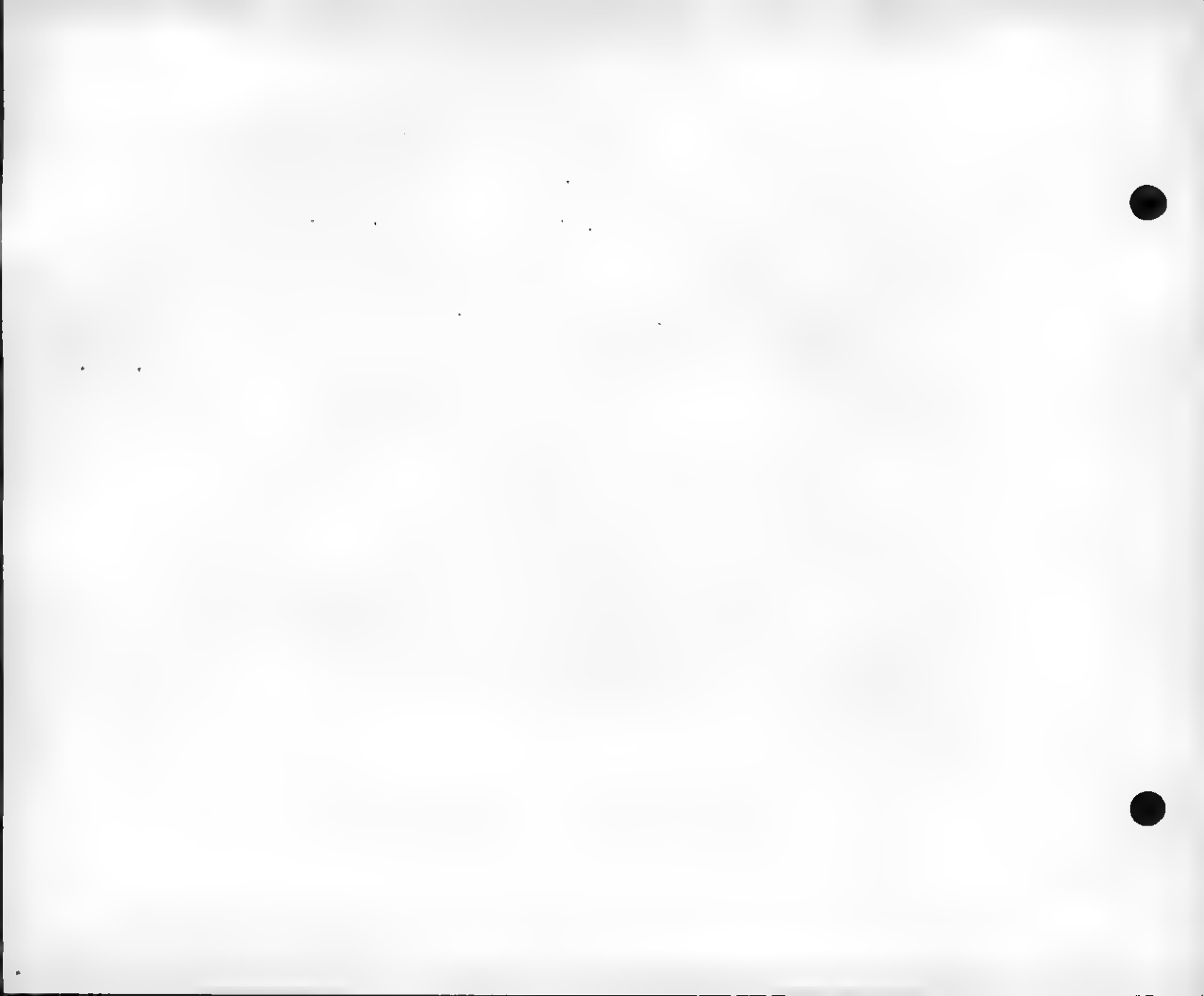
VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17470

1 PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel	
c. LENGTH OF STAY IN b. 5 days		d. STREET ADDRESS 1103 Scaggsville Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Amy Middle Driskill Last		4. DATE OF DEATH Month 12 Day 9 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-14-84
9. AGE (In years lost birthday) 83 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Counselor		10b. KIND OF BUSINESS OR INDUSTRY mental retardation school	
11. BIRTHPLACE (County & State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Deceased WILLIAM JOHNSON		14. MOTHER'S MAIDEN NAME Deceased MATTIE SMITH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. Medical Record	
17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION ACUTE 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS		19. WAS A T.O.P.S. PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12 4, 1967, to 12 9, 1967, that (I) (we) last saw the deceased alive on 12-9 1967, and that death occurred at 6:30 PM, from causes and on the date stated above.			
22a. SIGNATURE C. J. Houmann		22b. DATE SIGNED 12-9 67	
22c. PHYSICIAN'S NAME (Type) C. J. HOUMANN		22d. ADDRESS RIVERDALE MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-14-67	
23c. NAME OF CEMETERY OR CREMATORY Paradise Cemetery		23d. LOCATION (City or Town) (County) (State) Smithland Kentucky	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR DATE DEC 18 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



12 1

CERTIFICATE OF DEATH

17471

1. PLACE OF DEATH a. COUNTY <u>PR. Georges.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>md</u> b. COUNTY <u>PR. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 mos.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PR. Geo Gen'L Hospital</u>		d. STREET ADDRESS <u>4017 Jefferson St</u>	
3. NAME OF DECEASED (Type or print) <u>Thomas Howard Duckett</u>		DATE OF DEATH Month <u>Dec</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>7/28/80</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if not red) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Prince George Co., Md.</u>
13. FATHER'S NAME <u>Marion Duckett</u>		14. MOTHER'S MAIDEN NAME <u>Gabriella DuVal</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, not unknown, give service number and dates of service) <u>Spanish American</u>		16. SOCIAL SECURITY NO <u>218 01 9057</u>	17. INFORMANT Address <u>Josephine Dent Duckett Same as #2 (wife)</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Broncho pneumonia, Terminal</u> ++ DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u>Hypertensive (Cardio-Vascular) Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>2 1/2 mos</u> <u>2 yrs</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7/17</u> , 19 <u>67</u> , to <u>12/3</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/3</u> , 19 <u>67</u> , and that death occurred at <u>230</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Thomas Howard Duckett</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>12/3/67</u>
22c. PHYSICIAN'S NAME (Type) <u>Wonna N. Donta (Cameau)</u>		22d. ADDRESS <u>3503 Penny St Mt Rainier Md</u>	
23a. BURIAL, CREMATION, <u>BURIAL</u> (Specify)	23b. DATE THEREOF <u>12/6/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington D. C.</u>
24. FUNERAL DIRECTOR <u>Francis Gasch's Sons</u>		ADDRESS <u>Hyattsville, Md.</u>	25a. REC'D BY REGISTRAR <u>DEC 7 1967</u>
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



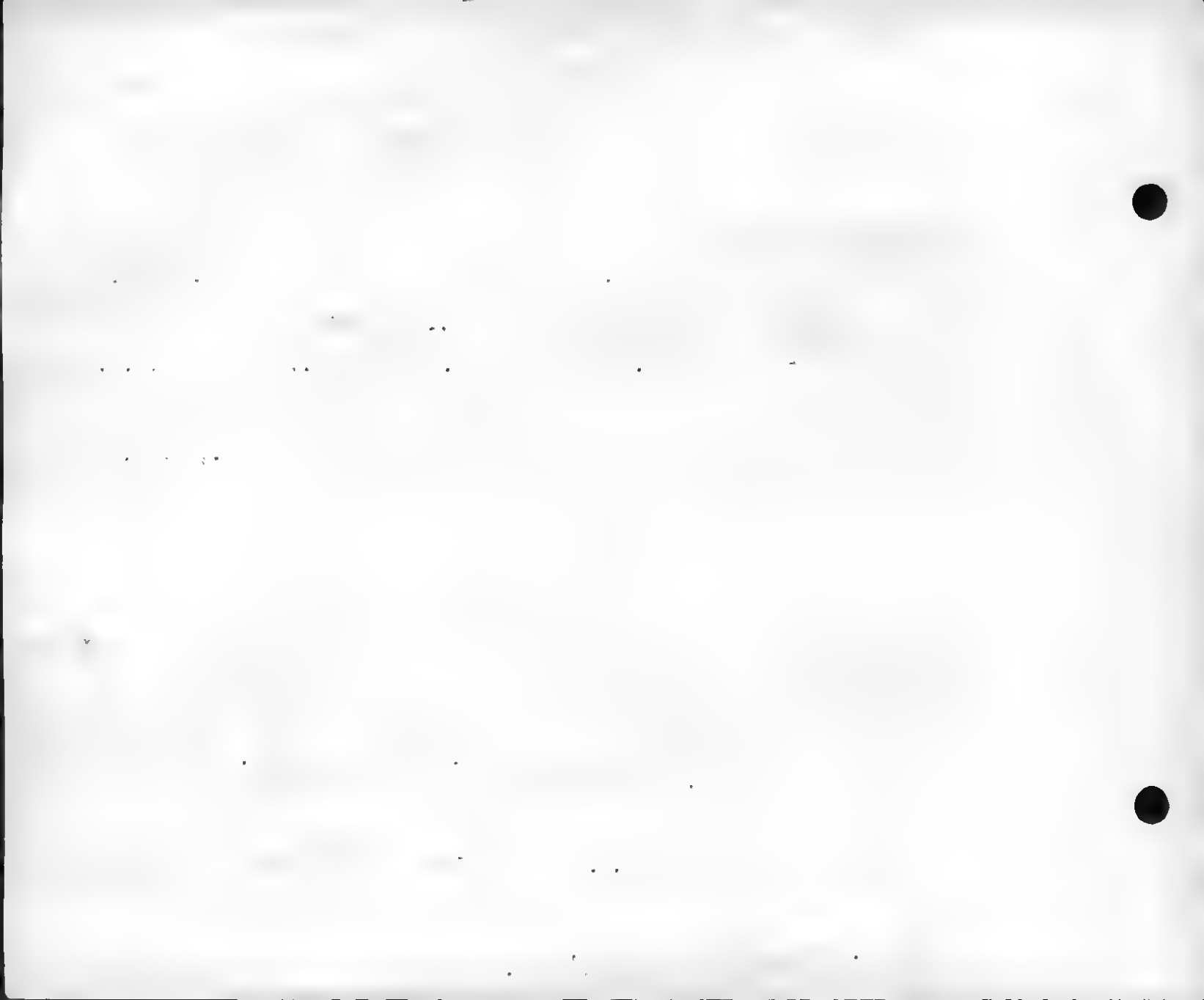
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c LENGTH OF STAY IN 1b 11 days			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				e STREET ADDRESS 7263 M Street			
3. NAME OF DECEASED (Type or print) First Middle Last John L. Dyson				4. DATE OF DEATH Month Day Year Dec. 21, 1967			
5 SEX Male	6 COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1873	9 AGE (in years last birthday) 94 YES	IF UNDER 1 YEAR Months Days Hours M.n.		IF UNDER 24 HRS M.n.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't		11 BIRTHPLACE (County & State, or foreign country) St. Mary's Co., Md.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John L. Dyson				14. MOTHER'S MAIDEN NAME Sallie Bennett			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO		17 INFORMANT Mrs. Jessie Perry 1364 Taylor St., NW Wash., D. C.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) coronary heart failure DUE TO (b) arteriosclerosis - heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)						INTERVAL BETWEEN ONSET AND DEATH 1 day years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia due to hyperkalemia - obstructive jaundice						19 WAS AUTOPSY PERFORMED? NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c TIME OF INJURY Month, Day, Year Hour o m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f (City or town) (County) (State)		21. I certify that (X) (this hospital) attended the deceased from Dec. 10, 1967 , to Dec. 21, 1967 , that (X) (we) last saw the deceased alive on Dec. 21, 1967 , and that death occurred at 9:05 AM , from causes and on the date stated above.			
22a SIGNATURE Till Bergemann				22b DATE SIGNED		22c PHYSICIAN'S NAME (Type) Till Bergemann, M.D.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 12/27/67		23c NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d LOCATION (City or Town) (County) (State) Wash., D.C.	
24 FUNERAL DIRECTOR Robert G. McQuinn ADDRESS 1820 9th St., N.W. Washington, D. C.				25a REC'D BY REG. STRAR DEC 29 1967		25b REGISTRAR'S SIGNATURE [Signature]	

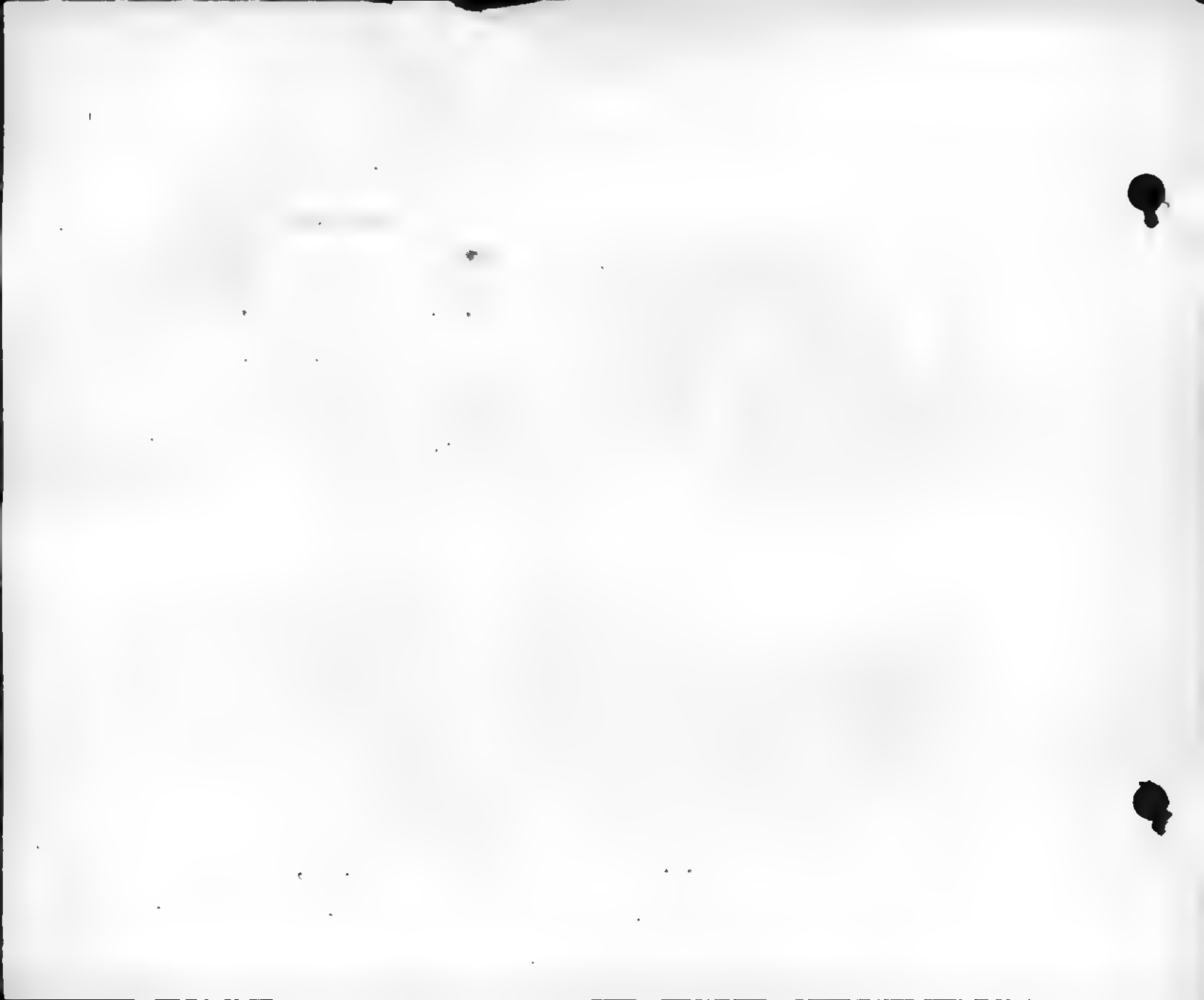


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any details are necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-5. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div>Item 18 Film 398 3/21/68</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>11473</div>									
1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> DOA c. LENGTH OF STAY IN ID d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Leland Memorial Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Calverton Beltsville</u> d. STREET ADDRESS <u>3302 Castleleigh Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Anne E. Ehlers</u>			4. DATE OF DEATH Month <u>December</u> Day <u>24</u> Year <u>1967</u>		5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Sept. 27, 1966</u> 9. AGE (In years last birthday) <u>15 mos.</u> IF UNDER 1 YEAR Months <u>15</u> Days <u>24</u> Hours <u>19</u> Min. <u>67</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> 11. BIRTHPLACE (State or foreign country) <u>Montgomery Co., Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Arthur Herbert Ehlers Jr.</u> 14. MOTHER'S MAIDEN NAME <u>Irene Carman</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>none</u> 17. INFORMANT <u>Arthur H. Ehlers Same as #2 (father)</u> Address			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Enterocolitis (negative stool culture)</u> DUE TO (b) <u>and interstitial pneumonitis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____						
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. _____ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____						
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. _____ p.m. _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____			21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <u>John Kehoe</u> EXAMINER'S NAME (Type) <u>John Kehoe, M.D.</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22. DATE SIGNED <u>12-26-67</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>12/28/67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u> 23d. LOCATION (City, town or county) <u>Baltimore</u> (State) <u>Md.</u>			24. FUNERAL DIRECTOR <u>Francis Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u> 25a. REC'D BY REGISTRAR <u>JAN 2 1968</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>						



1
FOR STATE
HEALTH DEPT.

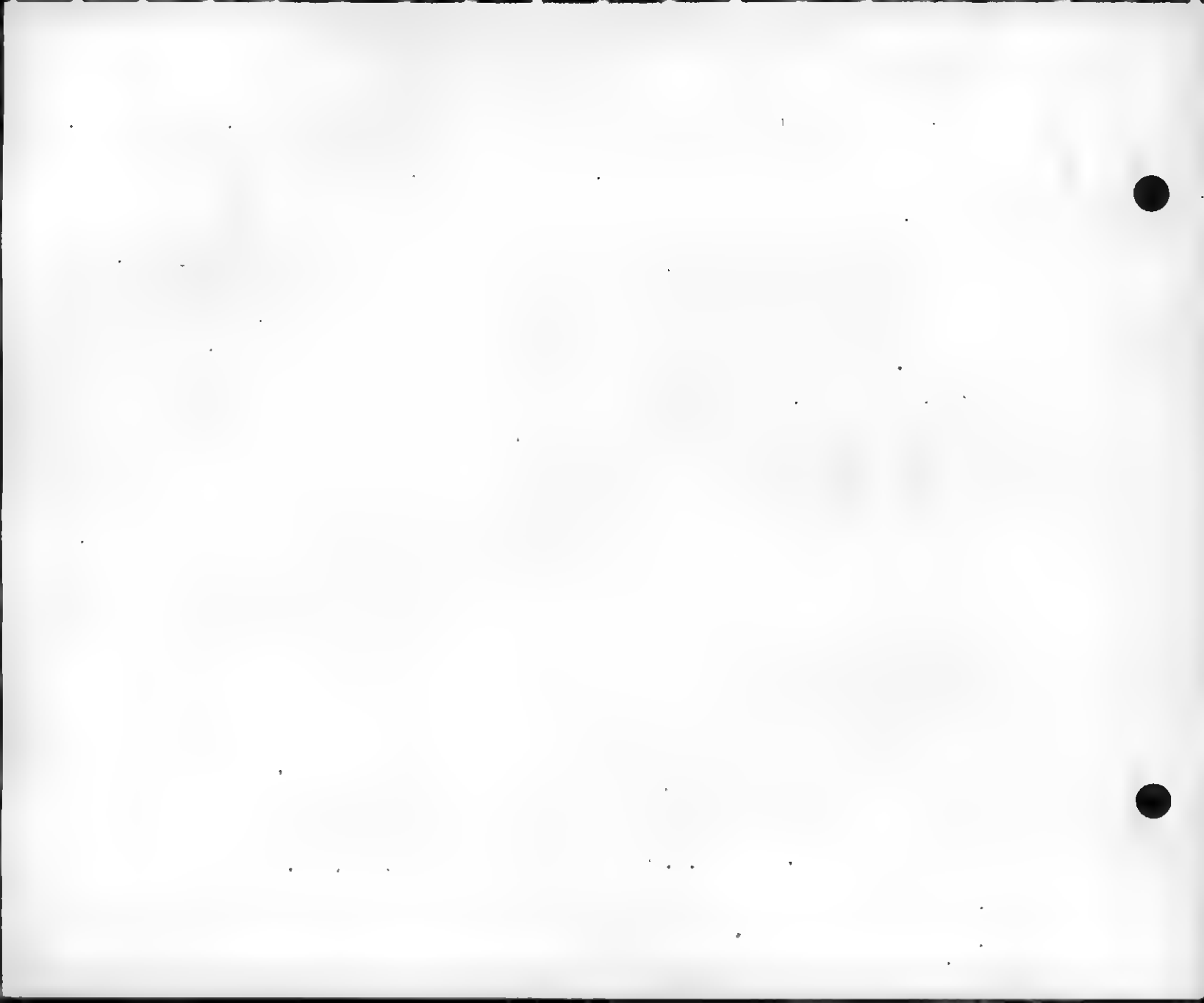
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1474

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale d. STREET ADDRESS 6305 Roanoke Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Greta Elizabeth Ellett		4. DATE OF DEATH Month Day Year December 28 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24, 1906
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE, Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME OLOF WESSBERG		14. MOTHER'S MAIDEN NAME ESTER ANDERSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO.	
17. INFORMANT OLOF H. WESSBERG		Address SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH minutes unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D.		M.O. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address Riverdale, Md. (County)	
22. DATE SIGNED 12-29-67			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-3-1968	
23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM		23d. LOCATION (City, town or county) (State) COLMAR MANOR MD	
24. FUNERAL DIRECTOR W.W. CHAMBERS Co. RIVERDALE, Md.		25a. REC'D BY REGISTRAR DATE JAN 2 1968	
25b. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

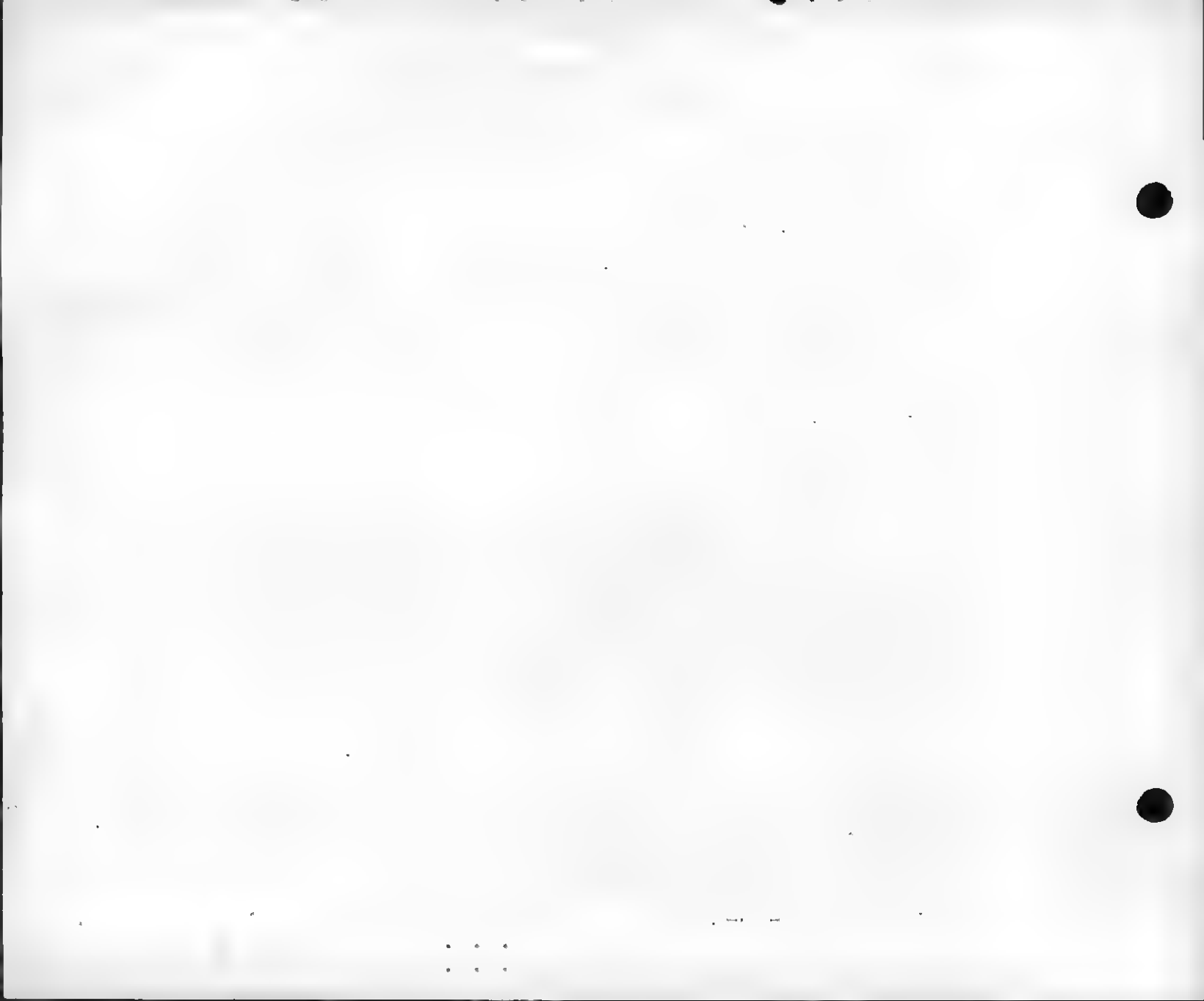
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11475

1 PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>6 HRS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL MANOR.</u>		d. STREET ADDRESS <u>2212 EYE ST. N.W.</u>	
3 NAME OF DECEASED (Type or print) <u>Agnes M. Eubright.</u>		4. DATE OF DEATH Month <u>12</u> Day <u>14</u> Year <u>1967</u>	
5. SEX <u>F.</u>	6 COLOR OR RACE <u>W.</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 22, 1975</u>
9 AGE (In years last birthday) yrs. <u>92</u>		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>COUNTY CORK, IRELAND.</u>		12 CIT ZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>DENNIS SULLIVAN</u>		14. MOTHER'S MAIDEN NAME <u>ANGELA McCarthy.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes (no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO. <u>218-56-8326</u>	
17. INFORMANT <u>Dr. M. Dolores.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic Cardiovascular</u> DUE TO <u>Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Generalized arteriosclerosis</u> DUE TO <u>9 years</u> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 30, 1958</u> to <u>Dec 14, 1967</u> that (I) (we) last saw the deceased alive on <u>Dec 13, 1967</u> and that death occurred at <u>6:30 AM</u> from causes and on the date stated above			
22a. SIGNATURE <u>Francis P. Hannan</u> M.D.		22b. DATE SIGNED <u>Dec. 14, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANCIS P. HANNAN</u>		22d. ADDRESS <u>1511-17 ST. N.W. WASH. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-16-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT OLIVET CEMETERY</u>	23d. LOCATION (City or town) (County) (State) <u>WASHINGTON D.C.</u>
24 FUNERAL DIRECTOR <u>Francis J. Collins</u>		ADDRESS <u>WASH. D.C.</u> <u>3821 14TH. ST. N.W.</u>	
25a. REC'D BY REGISTRAR <u>DEC 18 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Francis J. Collins</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

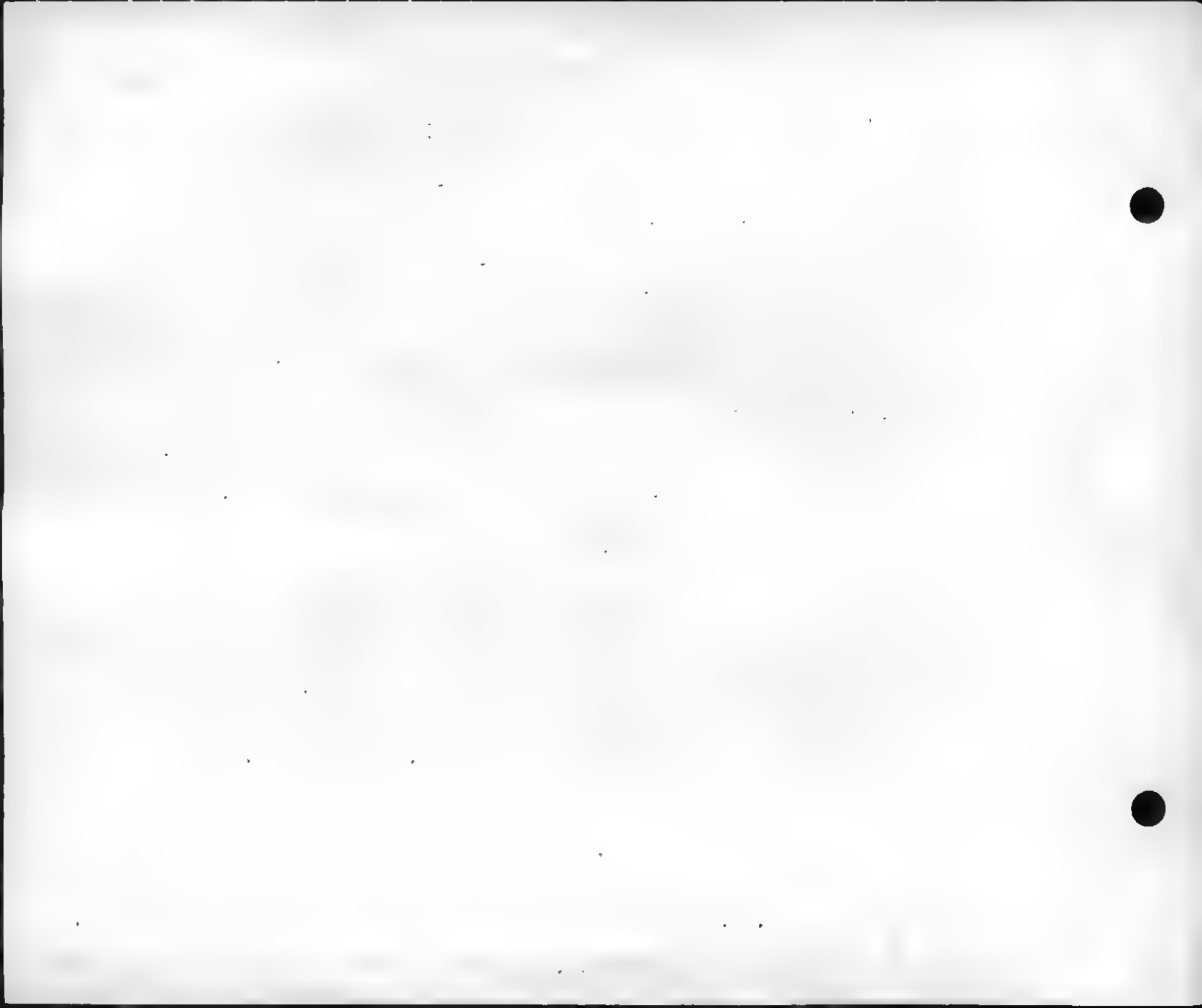
17472

17476

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 25 minutes		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie 16.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS Barn #17, Bowie Race Track e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Essex Last Essex		4. DATE OF DEATH Month Dec. Day 4 Year 1967	
5. SEX Malw	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1926
9. AGE (In years) 41 (last birthday) yrs		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. TRAINER		10b. KIND OF BUSINESS OR INDUSTRY RACE TRACK	
11. BIRTHPLACE (County & State or foreign country) Culpeper, VA		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME LIZZIE ROBINSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT MRS ANNIE ESSRX		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Intracerebral Hemorrhage 445X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertensive Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (H) (this hospital) attended the deceased from Dec. 4, 1967 , to Dec. 4, 1967 , that (H) (we) last saw the deceased alive on Dec. 4, 1967 , and that death occurred at 2:25 PM , from causes and on the date stated above.			
22a. SIGNATURE Till Bergemann		22b. DATE SIGNED Dec. 5, 1967	
22c. PHYSICIAN'S NAME (Type) Till Bergemann, M. D.		22d. ADDRESS Prince Georges General Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF Dec. 7, 1967	23c. NAME OF CEMETERY OR CREMATORY Smith Funeral Home	23d. LOCATION (City or town) (County) (State) Charlestown, West Va.
24. FUNERAL DIRECTOR Robert L. Snowden		25a. REC'D BY REGISTRAR Rockville, Maryland	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17477

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c. LENGTH OF STAY IN <u>10-26-67 to 12-4-67</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pine View Gardens Health Care Center</u>		d. STREET ADDRESS <u>7635 Surratts Road</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>W.</u> Last <u>Estep SR</u>		4. DATE OF DEATH Month <u>12</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-23-83</u>
9. AGE (In years last birthday) <u>84</u> yrs		10. IF UNDER 1 YEAR Months <u>12</u> Days <u>4</u> Hours <u>19</u> Min <u>67</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RAIL FR. HANDLER REX Railroad</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Charles Co., Md.</u>	
12. BIRTHPLACE (County, state, or foreign country) <u>USA</u>		13. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
14. FATHER'S NAME <u>James T. Estep</u>		15. MOTHER'S MAIDEN NAME <u>Blanche M. Carrico</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		17. SOCIAL SECURITY NO <u>A-442217 (Ad)</u>	
18. INFORMANT <u>M. Hard, RN</u>		Address <u>5905 Fisher Wash SE DC</u>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Acute congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular</u> DUE TO (c) <u>Disease with Healed Myocardial Infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>None</u>	
20c. TIME OF INJURY Month Day, Year Hour <u>None</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, other bldg., etc.) <u>None</u>		20f. (City or town) (County) (State) <u>None</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 1960</u> to <u>Present</u> , that (I) (we) last saw the deceased alive on <u>12/4/67</u> , and that death occurred at <u>5:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Arthur Shaver Jr.</u> M.D.		22b. DATE SIGNED <u>12/4/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ARTHUR SHAVER JR.</u>		22d. ADDRESS <u>8808 BRANCH AVE. CLINTON, MD.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>12-7-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST MARYS</u>	23d. LOCATION (City or Town) (County) (State) <u>BRYANTOWN, MD.</u>
24. FUNERAL DIRECTOR <u>HUNT FUNERAL HOME, WILDORF, MD.</u>		25a. REC'D BY REGISTRAR <u>DEC 11 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

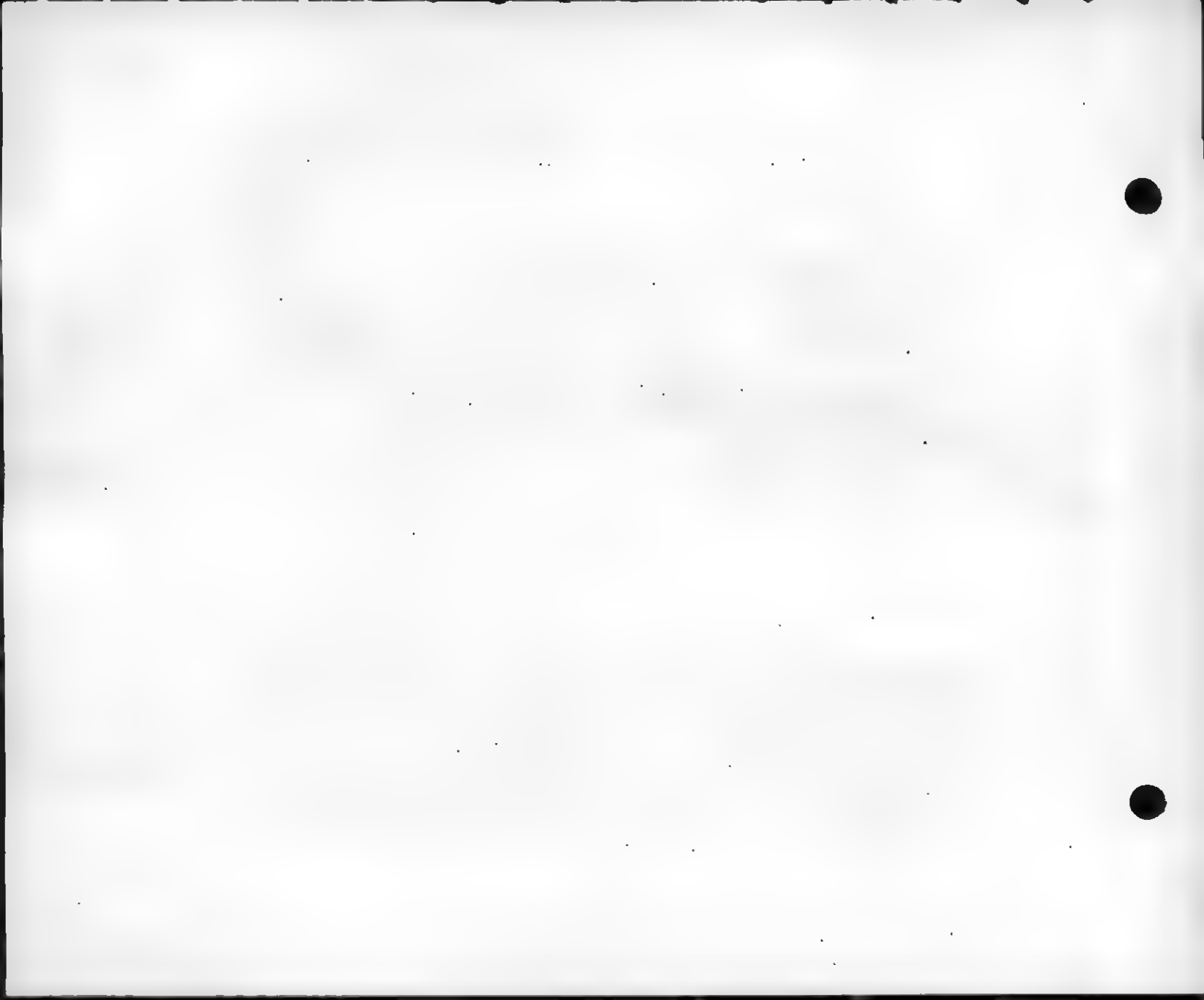
1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>PR. Geo.</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park.</u> c. LENGTH OF STAY IN 1b <u>10 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>404 ELM AVENUE</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Pr. Geo.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>404 Elm Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>VIOLET</u> Middle <u>MARIE</u> Last <u>FANN</u>		4. DATE OF DEATH Month <u>DEC</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>FE</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 24, 1917</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HSWK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE (In years last birthday) <u>50</u> yrs. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>
11. BIRTHPLACE (County & State, or foreign country) <u>New Hampshire.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Henry A. Mailhot</u>		14. MOTHER'S MAIDEN NAME <u>Ida B. Boisvert.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>husb - Geo.</u>		Address <u>same.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Acute necrotizing papillitis.</u> UNDERLYING CAUSE (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 mos.</u> <u>6 mos.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 9, 1967</u> to <u>Dec 7, 1967</u> , that (I) (we) last saw the deceased alive on <u>Dec 6, 1967</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>William F. Simpson</u>		22b. DATE SIGNED <u>12/7/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>William F. Simpson</u>		22d. ADDRESS <u>6216 N.H. Ave NE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec 9, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Silver Spring Md</u>
24. FUNERAL DIRECTOR <u>Takoma Funeral Home & John H. Hester, 254 Carroll Ave</u>		25. REC'D BY REGISTRAR <u>—</u> 25b. REGISTRAR'S SIGNATURE <u>Charles George</u>	



FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1479

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mitchellville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Felix</u> Last <u>Unknown</u>		4. DATE OF DEATH Month <u>12</u> Day <u>10</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>
9. AGE (In years last birthday) <u>62?</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart failure</u> Due to <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u> </u> (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.		22. DATE SIGNED <u>12-12-67</u>	
EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY <u>Anatomy Board of Hospital</u>	23d. LOCATION (City or town) (County) (State)
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>
		DATE <u>DEC 20 1967</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

John Kehoe, medical examiner notified & approved.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17480

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) b. COUNTY Maryland Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 5 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS Route #1, Box 84A		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Halsey C. Fitzgerald				4. DATE OF DEATH Month Day Year Dec. 21, 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10, 1904		9. AGE (In years lost birthday) 63 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Electric Co.		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Fitzgerald				14. MOTHER'S MAIDEN NAME Mary E. Coffey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 227 34 7389		17. INFORMANT Address Mary E. Fitzgerald Same as #2 (wife)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Post Op. Neurosurgery - Dissected Abdominal + Left Thorax. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Abdominal exploration - Splenic Vary. DUE TO (c) Cirrhosis of Liver - bleeding Esophageal Varices						INTERVAL BETWEEN ONSET AND DEATH 3 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) physician attended the deceased from 21 Dec , 1967, to 21 Dec , 1967, that (I) was last saw the deceased alive on 21 Dec , 1967, and that death occurred at 11:30 PM , from causes and on the date stated above.							
22a. SIGNATURE George S. Banning, Jr.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 22 Dec 67	
22c. PHYSICIAN'S NAME (Type) George S. Banning, Jr.				22d. ADDRESS 3408 Rhode Island Ave., Mt. Rainier, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/26/67		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.	
24. FUNERAL DIRECTOR ADDRESS Francis Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR DEC 28 1967		25b. REGISTRAR'S SIGNATURE John Kehoe	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17481

1 PLACE OF DEATH a. COUNTY PRINCE GEORGE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BLADENSBURG	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PRINCE GEORGE GENERAL HOSPITAL		d. STREET ADDRESS 4315-57th Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First MARGUERITE Middle T. Last FORESTER		4. DATE OF DEATH Month Dec Day 2 Year 1967	
5 SEX Female	6. CO. OR OR RACE Cau	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 June 1898 9. AGE (In years (last birthday)) 69 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (County & State or foreign country) Tennessee
13. FATHER'S NAME Robert Lee Talbert		14. MOTHER'S MAIDEN NAME Margaret C. Scobell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO none	17. INFORMANT Address Talbert L. McCarthy Son Same as #2
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Aneurysm DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Dilated Cardiomyopathy (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 11-29 , 19 67 , to 12-2 , 19 67 , that (I) (we) last saw the deceased alive on 12-1 , 19 67 , and that death occurred at 5:20 A.M. from causes and on the date stated above.			
22a. SIGNATURE S. Deitz		22b. DATE SIGNED 12-2-67	
22c. PHYSICIAN'S NAME (Type) Saron Deitz, M.D.		22d. ADDRESS Prince George's Plaza Hyattsville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/5/67	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.	23d. LOCATION (City or town) (County) (State) Arlington Virginia
24. FUNERAL DIRECTOR F. Gasch's Sons		25a. REC'D BY REGISTRAR Hyattsville, Maryland	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE DEC 5 1967	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

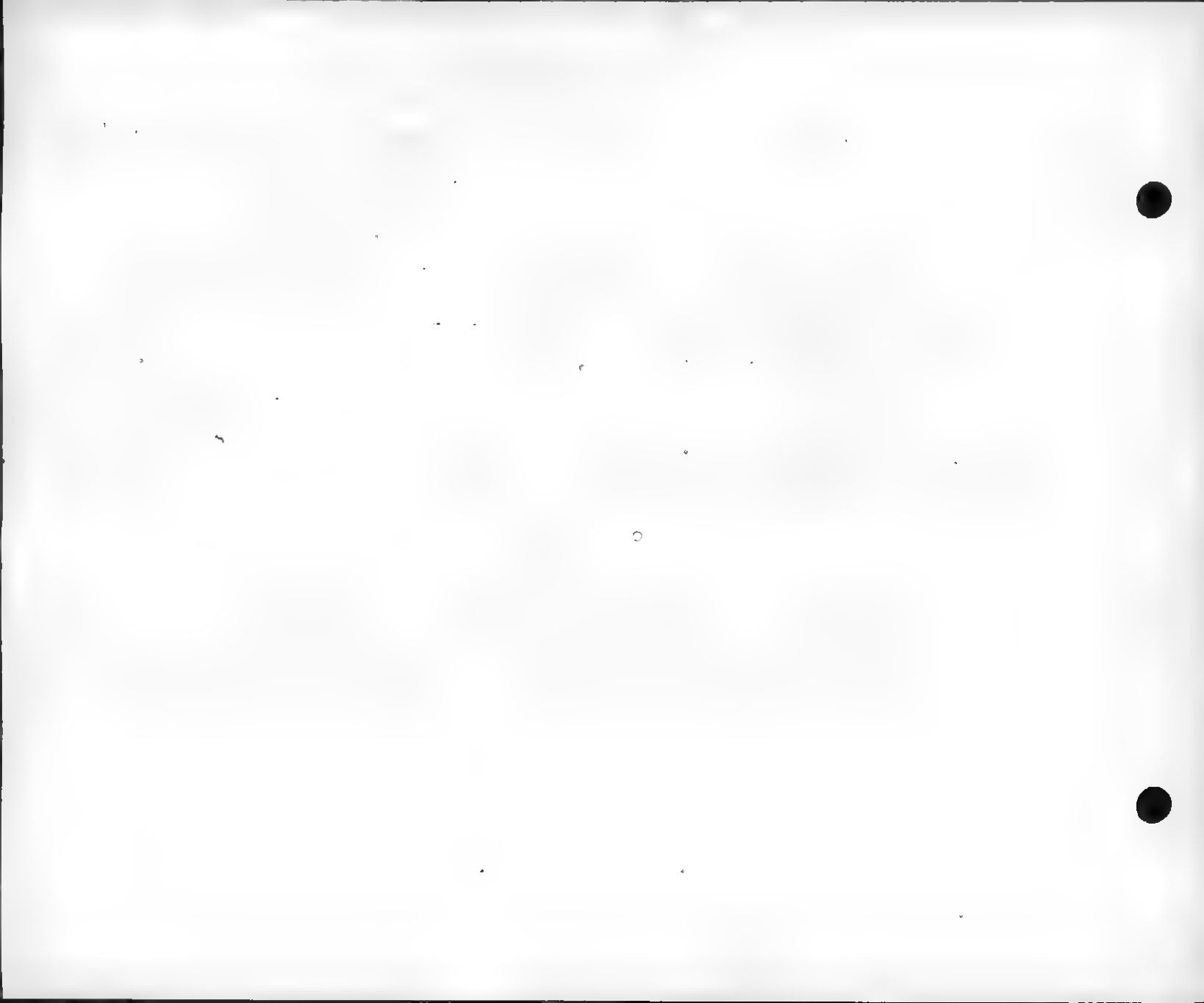
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>			c. LENGTH OF STAY IN 1b <u>DOA</u>		c CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Brentwood</u>		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>				d STREET ADDRESS <u>4501 38th. Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert William Francisco</u>				4 DATE OF DEATH Month Day Year <u>12 9 19 67</u>			
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>8-18-1925</u>	9 AGE (In years last birthday) <u>42</u> yrs	IF UNDER 1 YEAR Months Days Hours Min		
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAINTENANCE TECHNICIAN</u>			10b KIND OF BUSINESS OR INDUSTRY <u>R.C.A. COMMUNICATIONS</u>		11 BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		
12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			13 FATHER'S NAME <u>BURTON FRANCISCO</u>				
14 MOTHER'S MAIDEN NAME <u>ELEANOR HUBBARD</u>			15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES W.W.II</u>				
16 SOCIAL SECURITY NO <u>212 20 6541</u>			17 INFORMANT <u>MARY C. FRANCISCO, SAME AS #2</u>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart failure</u> + 301 DUE TO <u>Thrombosis of left coronary artery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)		
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED		
EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE THEREOF		23c NAME OF CEMETERY OR CREMATORY		
<u>BURIAL</u>			<u>12-12-1967</u>		<u>GLEN HAVEN CEM</u>		
24 FUNERAL DIRECTOR <u>W.W. CHAMBERS CO., RIVERDALE, MARYLAND</u>			25a REC'D BY REGISTRAR <u>DEC 14 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

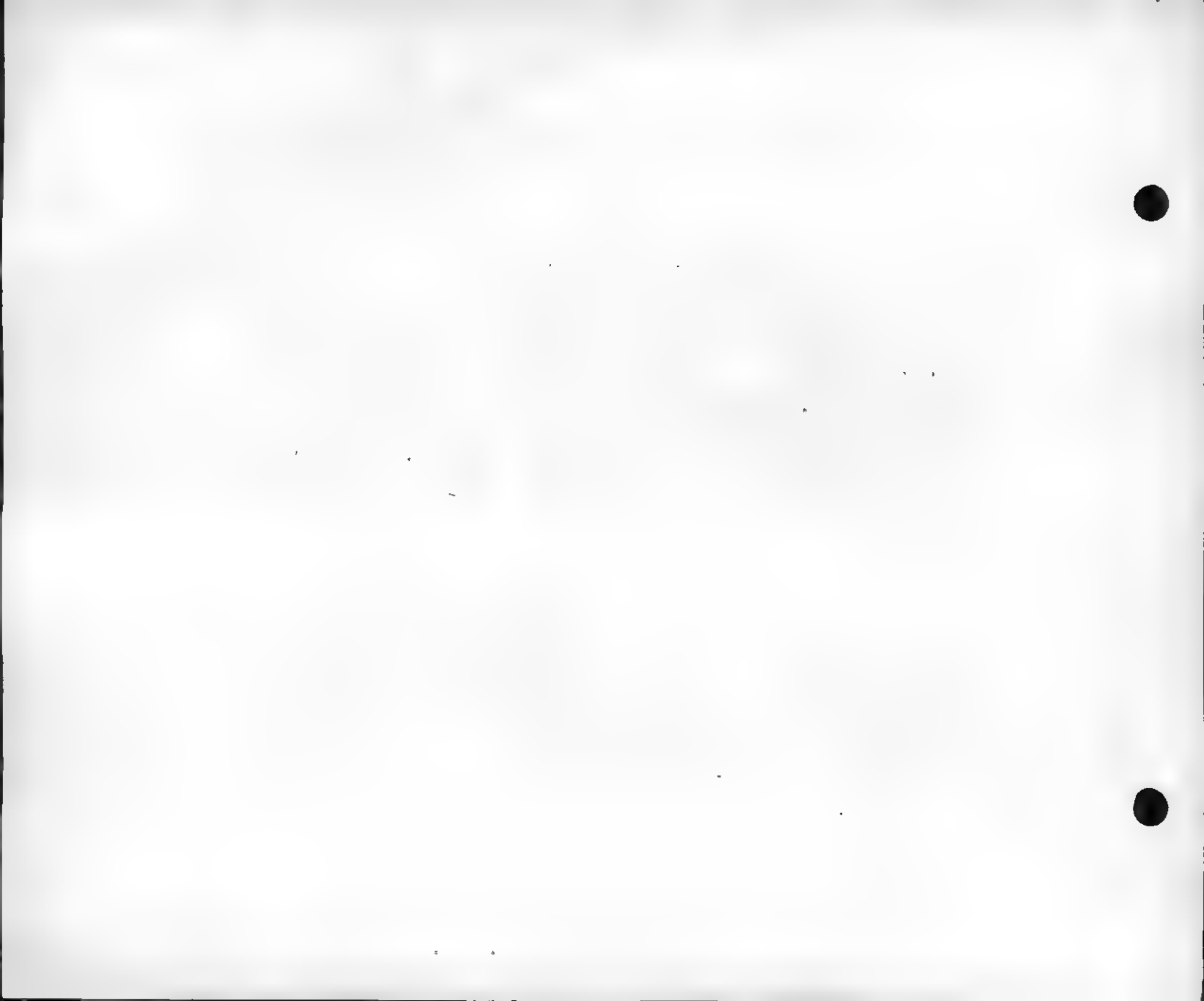


CERTIFICATE OF DEATH

11483

1 PLACE OF DEATH a COUNTY <u>Prince George's</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>District of Columbia</u> b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c LENGTH OF STAY in lb <u>26 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, DC.</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Mary Margaret Alger Frownfelter</u>		d STREET ADDRESS <u>3004 Fairlawn Street</u>	
4. DATE OF DEATH Month Day Year <u>Dec. 24, 1967</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1/20/1914</u>
9 AGE (in years lost birthday) <u>53</u> yrs		IF UNDER 1 YEAR Months Days Hours Min. <u>xx</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Exm. U.S. Gov't</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Treasury Dept</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Danridge E. Collier</u>		14. MOTHER'S MAIDEN NAME <u>Eva Saunders</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Howard L. Frownfelter-Husband</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hepatic failure</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Nutritional cirrhosis</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11-28</u> , 19 <u>67</u> , to <u>12-24</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>12-23</u> 19 <u>67</u> , and that death occurred at <u>9 A</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>Ken B. Cameron</u> M.D.		22b. DATE SIGNED <u>Dec 24, 1967</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/28/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ivy Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Laurel, Md.</u>
24. FUNERAL DIRECTOR <u>Lee Funeral Home</u>		25a. REC'D BY REGISTRAR <u>DEC 28 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

PR A15 (A)
20 M 1/66

430

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17484

1 PLACE OF DEATH a COUNTY <u>Prince Georges</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u>		c LENGTH OF STAY IN 1b <u>20 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greenbelt Convalescent Center</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Gaither, Augustus</u>		4. DATE OF DEATH <u>December 29 1967</u>	
5 SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/19/91</u>
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12 CIT ZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Elvis Gaither</u>		14. MOTHER'S MAIDEN NAME <u>Alberta Brooks</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.	
17. INFORMANT <u>Emma Gaither</u>		Address <u>11730 Ellington Dr. Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO (b) <u>Pulmonary Carcinoma, bilateral</u> DUE TO (c) <u>3 mos</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diverticulitis</u>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> of work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/1/67</u> to <u>12/27/67</u> , that (I) (we) last saw the deceased alive on <u>12/26/67</u> , and that death occurred at <u>2:30</u> M, from causes and on the date stated above.			
22a SIGNATURE <u>Dr. Henry A. Wise</u>		22b DATE SIGNED	
22c PHYSICIAN'S NAME (Type) <u>Henry A. Wise</u>		22d ADDRESS <u>13008 9th St, Bowie, Md</u>	
23a BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>12-30-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>St. Paul's Em. Harman R. A. Co</u>	23d LOCATION (City or Town) (County) (State) <u>Md.</u>
24 FUNERAL DIRECTOR <u>Rayner Sanders</u>		25a REC'D BY REGISTRAR <u>HC 29 1967</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

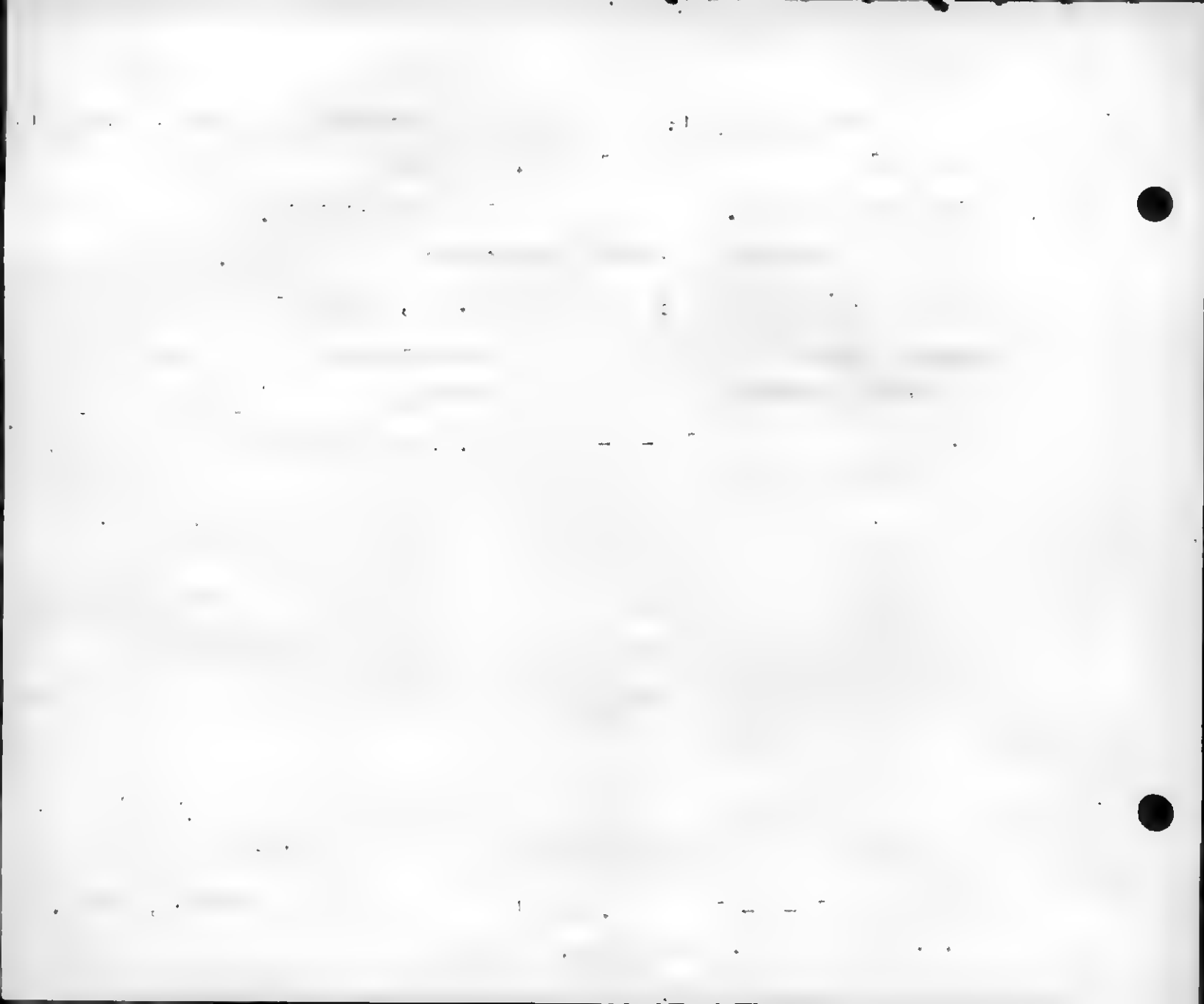


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Greenbelt		c. LENGTH OF STAY IN ID 18 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 109 Greenhill Rd.		e. STREET ADDRESS 109 Greenhill Rd.	
3. NAME OF DECEASED (Type or print) Michael Joseph Gallagher		4. DATE OF DEATH Dec. 18 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 24, 1876
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Theatre Manger		9b. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) 91 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Theatre Manger		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Pennsylvania
13. FATHER'S NAME Edward Gallagher		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or, unknown) NO		16. SOCIAL SECURITY NO. 170-10-9391	
17. INFORMANT Mrs. Peter Evanosky		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure		INTERVAL BETWEEN ONSET AND DEATH 7 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease & atrial fibrillation			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 18 1967 to 12-18 1967 , that (I) (we) last saw the deceased alive on Dec. 18 1967 , and that death occurred at 5-PM , from the causes and on the date stated above.			
22a. SIGNATURE Hans Wodak		22b. DATE SIGNED 12-19-67	
22c. PHYSICIAN'S NAME (Type) HANS WODAK M.D.		22d. ADDRESS GREENBELT, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-22-67	
23c. NAME OF CEMETERY OR CREMATORY St. Mary's		23d. LOCATION (city, town or county) (State) Upper Pittston, Penna.	
24. FUNERAL DIRECTOR W.W. Chambers Co.		25a. REC'D BY REGISTRAR DEC 26 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17486

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the hospital director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN TB One day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital			d. STREET ADDRESS 5511 - 59th Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last Lucy Elizabeth Garrettsen			4 DATE OF DEATH Month Day Year December 20 1967		
5 SEX F	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/22/77	9. AGE (n years last birthday) 90 yrs	10 UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Virginia	
13. FATHER'S NAME Beaty, Henry			14. MOTHER'S MAIDEN NAME Little, Mary		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 212-52-0907		17 INFORMANT 5511 - 59th Ave. Knott, Mary Riverdale, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO (b) ACUTE MYOCARDIAL INFARCTION DUE TO (c) (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.)					INTERVAL BETWEEN ONSET AND DEATH ONE DAY
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 1967 , to 12-20 1967 , that (I) (we) last saw the deceased alive on 12-20 1967 , and that death occurred at 8:10 P.M. from causes and on the date stated above					
22a. SIGNATURE C. J. Houmann		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 12/20/67	
22c. PHYSICIAN'S NAME (Type) Dr. C.J. Houmann, M.D.		22d. ADDRESS 4400 Queensbury Rd. Riverdale.			
23a. BURIAL, CREMATION, RURAL (Specify)	23b. DATE THEREOF Dec. 23, 67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR Simmons Bros. 1661-Gd. Hope Rd. SE. DC.		ADDRESS Wash. DC.		25a. REC'D BY REGISTRAR DEC 26 1967	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY Prince George MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b. COUNTY Prince George	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN 1b 2 weeks	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d STREET ADDRESS No. 10 Cheverly Circle	
3 NAME OF DECEASED (Type or print) First Martha Middle T. Last Gast		4 DATE OF DEATH Month Dec Day 22 Year 67	
5. SEX Female	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 10, 1881
9. AGE (In years last birthday) 86 yrs		10. IF UNDER 1 YEAR Months 22 Days 19 Hours 67	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY Own Home	
11 BIRTHPLACE (County & State, or foreign country) Mo.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Gustave Troemel		14. MOTHER'S MAIDEN NAME Emily T. Moser	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO none	
17. INFORMANT Fred W. Gast Same as #2 (husband)		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO (b) Myocardial Infarct DUE TO (c) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH 24 hours	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Dec 22, 1967 to Dec 22, 1967 , that (I) (we) last saw the deceased alive on Dec 22, 1967 , and that death occurred at 5:25 PM , from causes and on the date stated above			
22a SIGNATURE <i>Thomas M. Hutchins</i>		22b. DATE SIGNED 12/23/67	
22c PHYSICIAN'S NAME (Type) Thomas M. Hutchins, M.D.		22d. ADDRESS 7315 Landover Rd Landover, Md.	
23a BURIAL CREMATION, etc. Entombment		23b DATE THEREOF 12/26/67	
23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE DEC 29 1967	
25b REGISTRAR'S SIGNATURE			



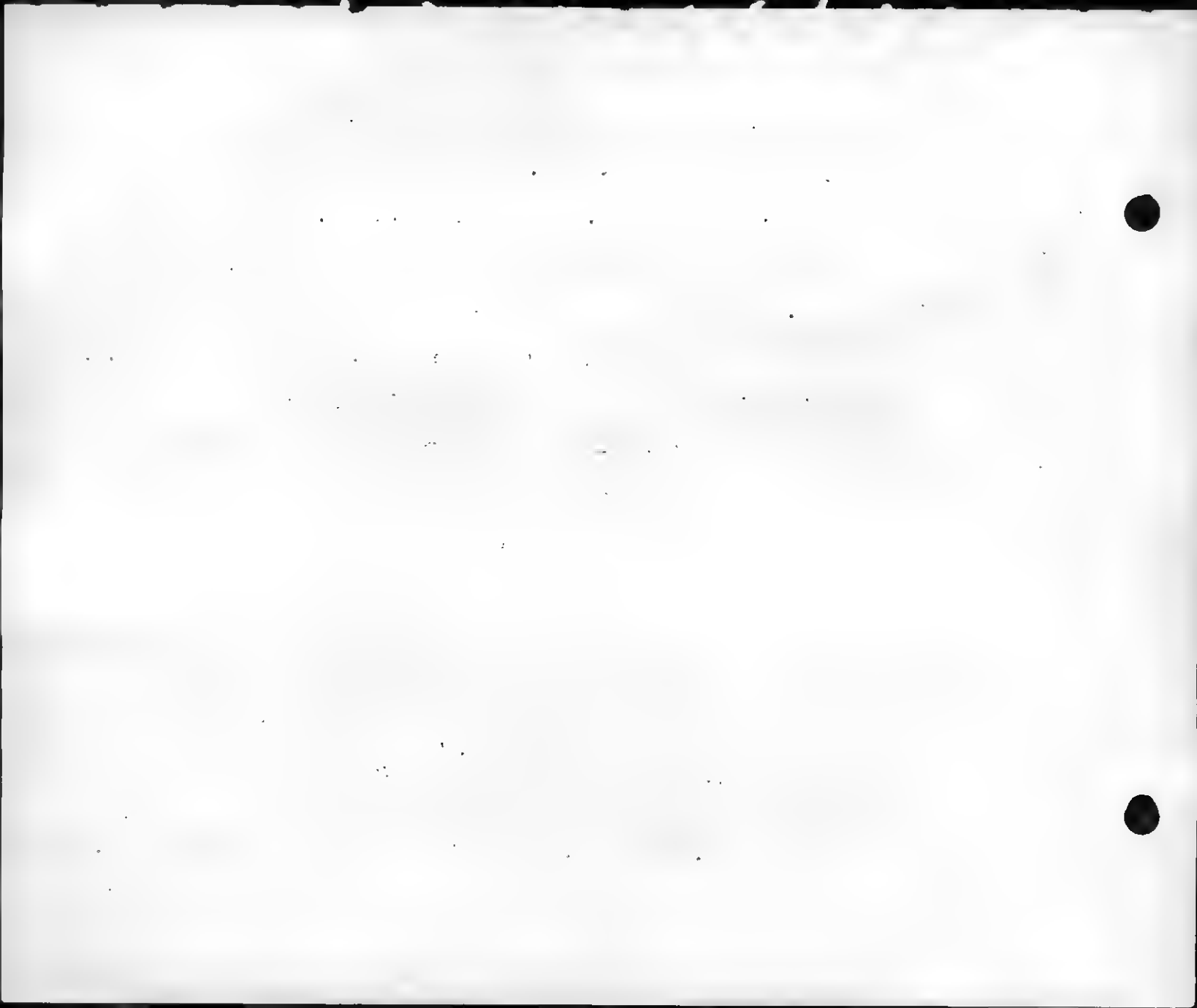
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove Carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
20M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE c. LENGTH OF STAY IN 1b 1 yr. 3 mo. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Manor 4922 LaSalle Rd.				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 165 Green St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) Mary Katherine Geraci		4. DATE OF DEATH Dec. 22 1967		5. SEX female		6. COLOR OR RACE Cau.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-5-1880		9. AGE (In years last birthday) 87 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse		11. BIRTHPLACE (County & State, or foreign country) Annapolis, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Onotrio Geraci				14. MOTHER'S MAIDEN NAME Mary Ellen Noonan				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 217-26-6780				17. INFORMANT Sister Elizabeth Carroll Manor			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____ INTERVAL BETWEEN ONSET AND DEATH 2 days																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)																			
21. I certify that (I) (this hospital) attended the deceased from Sept. 6, 1966, to Dec. 22, 1967, that (I) (we) last saw the deceased alive on Dec. 21, 1967, and that death occurred 3:55 M, from the causes and on the date stated above. 22a. SIGNATURE <i>Thomas F Collins</i> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. a DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 12/22/67 22c. PHYSICIAN'S NAME (Type) Thomas F Collins, M.D. 22d. ADDRESS 322 H St. N.E., Washington, D.C. 20002																			
23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 12/26/67 23c. NAME OF CEMETERY OR CREMATORY ST MARY SCM. 23d. LOCATION (City, town or county) (State) ANNAPOLIS MD 24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JOHN M. TAYLOR SOWS ANNAPOLIS MD DATE DEC 27 1967																			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

485

11489

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Wash. D.C.</u> b. COUNTY <u>4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyalssville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wash. D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Manor 4922 La Salle Rd</u>		d. STREET ADDRESS <u>4801 Conn. Ave N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Adele</u> Middle <u>R</u> Last <u>Gibbs</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 3, 1879</u>
9. AGE (In years last birthday) <u>88 yrs</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Geneste</u>		14. MOTHER'S MAIDEN NAME <u>Emma Ticker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-62-4669</u>	
17. INFORMANT <u>Spurredette Joseph</u>		Address <u>Hyalssville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <u>Hypostatic Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adenocarcinoma of Breast & Metastases</u> DUE TO (c) <u>Chronic Myocarditis per the camp.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>11 yrs</u> <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3/18/35</u> to <u>12/2/67</u> , that (I) (we) last saw the deceased alive on <u>12/1/67</u> , and that death occurred at <u>9:15</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>H. T. Morse</u> M.D.		22b. DATE SIGNED <u>12/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>H. T. Morse</u>		22d. ADDRESS <u>7030 Carroll Ave Takoma Park Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec 5, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Washington D.C.</u>
24. FUNERAL DIRECTOR <u>Takoma Funeral Home, J. Arthur Walker 254 Carroll Ave NW</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 5 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

285

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #23b Filed 12-12-67

CERTIFICATE OF DEATH

11491

1 PLACE OF DEATH a COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) b COUNTY Maryland Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 27 days			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d STREET ADDRESS 603 60th Place			
3 NAME OF DECEASED (Type or print) First Middle Last James Gordon				4 DATE OF DEATH Month Day Year Dec., 6 1967			
5 SEX Male	6. COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 18 Sept., 1911	9 AGE (n years lost birthday) 56 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bushy eye - Bishop		10b. KIND OF BUSINESS OR INDUSTRY Bishop		11 BIRTHPLACE (County, State, or foreign country) Shelby, N.C.		12 CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John F. Gordon		14. MOTHER'S MAIDEN NAME Pauline Gordon		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16 SOCIAL SECURTY NO.		17 INFORMANT Mrs. Pauline Gordon		Address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Inoperable carcinoma of esophagus DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardexia Dehydration						19 WAS A TOLPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)			
21. I certify that (X) (this hospital) attended the deceased from Nov. 10, 1967 to Dec. 6, 1967 that (X) (we) last saw the deceased alive on Dec. 6, 1967 , and that death occurred at 3.30AM , from causes and on the date stated above.							
22a. SIGNATURE Bahram Erfan				22b. DATE SIGNED Dec.		22c. PHYSICIAN'S NAME (Type) Bahram Erfan, M.D.	
22d. ADDRESS Prince Georges General Hospital				22e. LOCATION (City or Town) (County) (State) PRINCE GEORGES COUNTY, MD.			
23a BURIAL, CREMATION, REMOVAL (Specify)		3b DATE THEREOF 12/18/67		23c. NAME OF CEMETERY OR CREMATORY HARMONY MEMORIAL		23d. LOCATION (City or Town) (County) (State)	
24 FUNERAL DIRECTOR BROWN & DAVIDSON F.H. INC.		25a. RECEIVED BY REGISTRAR DEC 14 1967		25b. REGISTRAR'S SIGNATURE Johnas Judge			



1
48
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

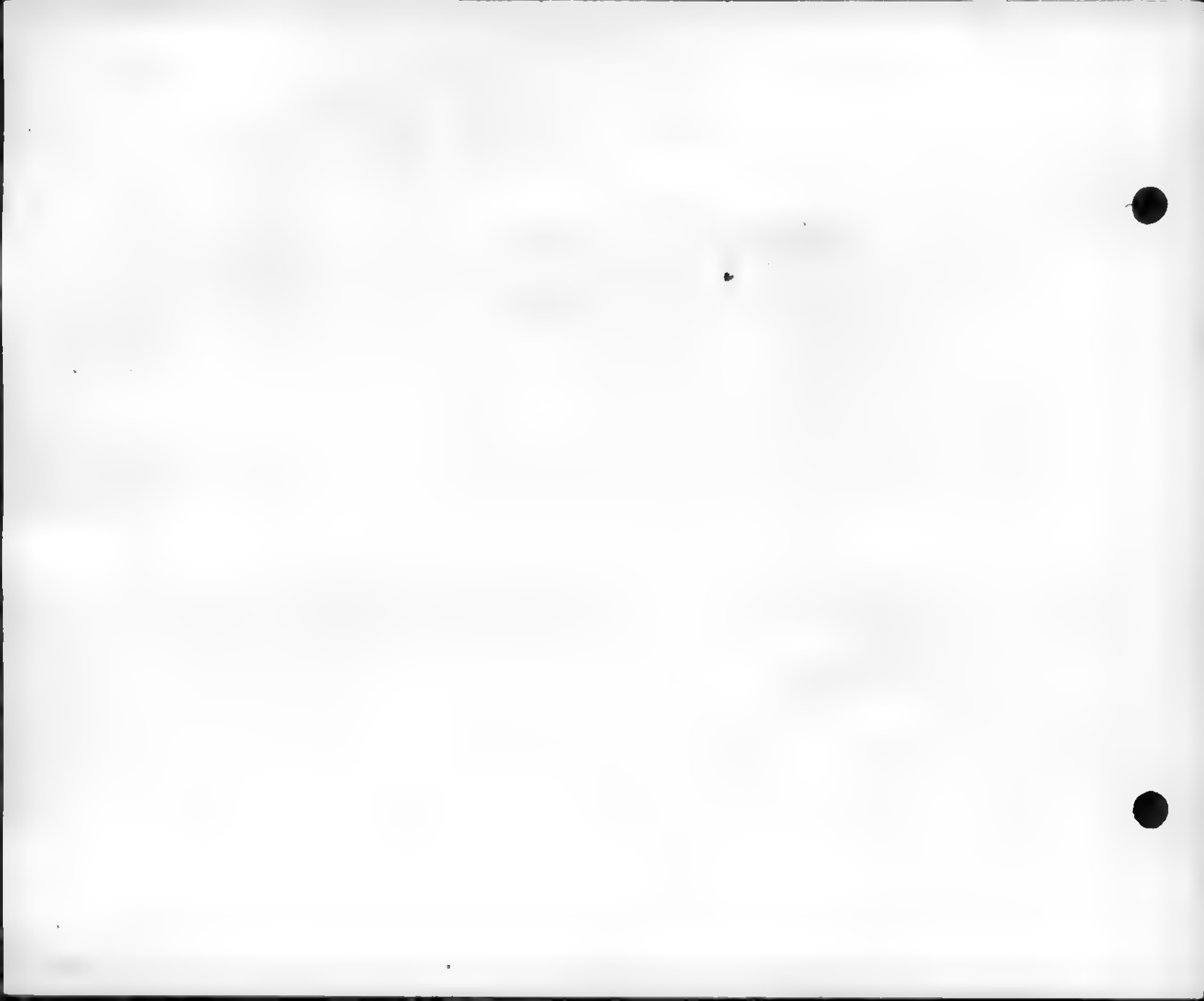
CERTIFICATE OF DEATH

1149

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CORONER NOTIFIED & APPROVED
MEDICAL CERTIFICATION

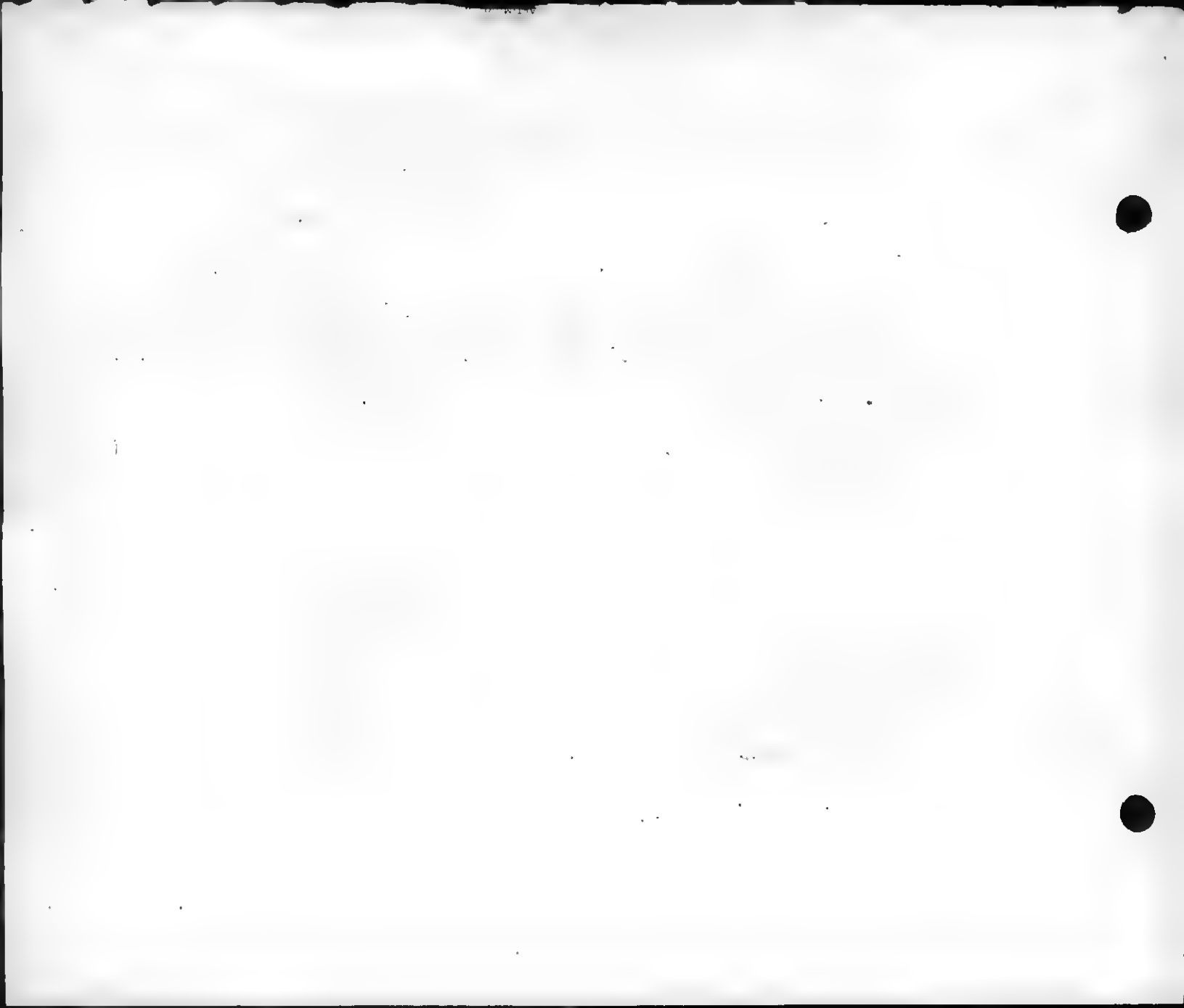
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D O A	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 12504 Saber Lane	
3. NAME OF DECEASED (Type or print) James L. Graham		4. DATE OF DEATH December 30 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-21-1926
9. AGE (in years last birthday) 41 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proof Reader		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	
11. BIRTHPLACE (County & State, or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Abel Graham		14. MOTHER'S MAIDEN NAME Mora Breedwell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes W W II		16. SOCIAL SECURITY NO 412 20 2448	
17. INFORMANT 12504 Saber Lane Ruth G Graham Bowie, Maryland, (Wife)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from August 1, 1964, to DEC 30, 1967, that (I) (we) last saw the deceased alive on DEC 14, 1967, and that death occurred at 7:30 PM, from causes and on the date stated above			
22a. SIGNATURE Clyde L. Bell Jr		22b. DATE SIGNED JAN 1 1968	
22c. PHYSICIAN'S NAME (Type) Clyde L. Bell Jr MD		22d. ADDRESS 12639 MILLSTREAM Drive PG Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-3-1968	
23c. NAME OF CEMETERY OR CREMATORY Green Lawn Cemetery		23d. LOCATION (City or town) (County) (State) Portsmouth, Virginia.	
24. FUNERAL DIRECTOR Valley Funeral Home		25a. REC'D BY REGISTRAR DATE JAN 8 1968	
25b. REGISTRAR'S SIGNATURE Charles Judge			



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 1,493

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bowie				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bowie			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 3006 Bendix Lane				d. STREET ADDRESS 3006 Bendix Lane			
3. NAME OF DECEASED (Type or print) First PEARL Middle E. Last GRIEASHAMER				4. DATE OF DEATH Month DECEMBER Day 5 Year 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 25, 1892	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min.		IF UNDER 24 HRS. Months 75 Days 75 Hours 75 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Illinois	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Eldridge Powell				14. MOTHER'S MAIDEN NAME Nellie Munson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. 579 28 9940		17. INFORMANT Edward Grieashamer Same as #2 (son)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA DUE TO (b) ACUTE MYOCARDIAL FAILURE DUE TO (c) ARTERIOSCLEROTIC, HYPERTENSIVE C-V DISEASE				INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 2 DAYS 15 YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from SEPT. 1963 , to 12-5- , 1967, that (I) (we) last saw the deceased alive on 12-5- , 1967, and that death occurred at 10³⁵ P.M. from the causes and on the date stated above.							
22a. SIGNATURE John Cosma, M.D.				22b. DATE SIGNED 12-5-67		22c. PHYSICIAN'S NAME (Type) JOHN COSMA, M.D.	
22d. ADDRESS BOWIE, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/8/67		23c. NAME OF CEMETERY OR CREMATORY George Washington		23d. LOCATION (City, town or county) (State) Hyattsville P.G. Md.	
24. FUNERAL DIRECTOR Francis Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DEC 11 1967	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11494

1 PLACE OF DEATH a. COUNTY Prince George MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY P. G.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARLOW HgTS, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pine View Garden Nursing Home		d. STREET ADDRESS 6320 Dallas Pl.	
3 NAME OF DECEASED (Type or print) First Middle Last NORBERT GRUBBS		4. DATE OF DEATH DEC 17 19 67	
5 SEX M	6 COLOR OR RACE CAUC.	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8 DATE OF BIRTH 3 JUNE 1881
9 AGE (In years last birthday) 86 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MILL WRIGHT	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) VIRGINIA	
12 CITIZEN OF WHAT COUNTRY? U.S.		13 FATHER'S NAME AUGUSTINE S. GRUBBS	
14 MOTHER'S MAIDEN NAME SARAH CATHERINE KELLER		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16 SOCIAL SECURITY NO 412-61-4387A		17 INFORMANT Address Virginia S. Tayman 6320 Dallas Pl Marlow	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4300 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO DISEASE (c) GENERALIZED ARTERIOSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 5 OCT, 19 67, to 17 DEC, 19 67, that (I) (we) lost saw the deceased alive on 17 DEC, 19 67, and that death occurred at 6:11 P.M. from causes and on the date stated above.			
22a. SIGNATURE Alfred R. Lerner M.D.		22b. DATE SIGNED 17 DEC 1967	
22c. PHYSICIAN'S NAME (Type) Alfred R. Lerner M.D.		22d. ADDRESS 1200 N. ...	
23a. B. RIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-19-1967	
23c. NAME OF CEMETERY OR CREMATORY Washington National		23d. LOCATION (City or Town) (County) (State) Suitland Maryland	
24 FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road Suitland Maryland		25a. REC'D BY REGISTRAR DATE DEC 21 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3 (Post-mortem). 5 may be retained for your files.

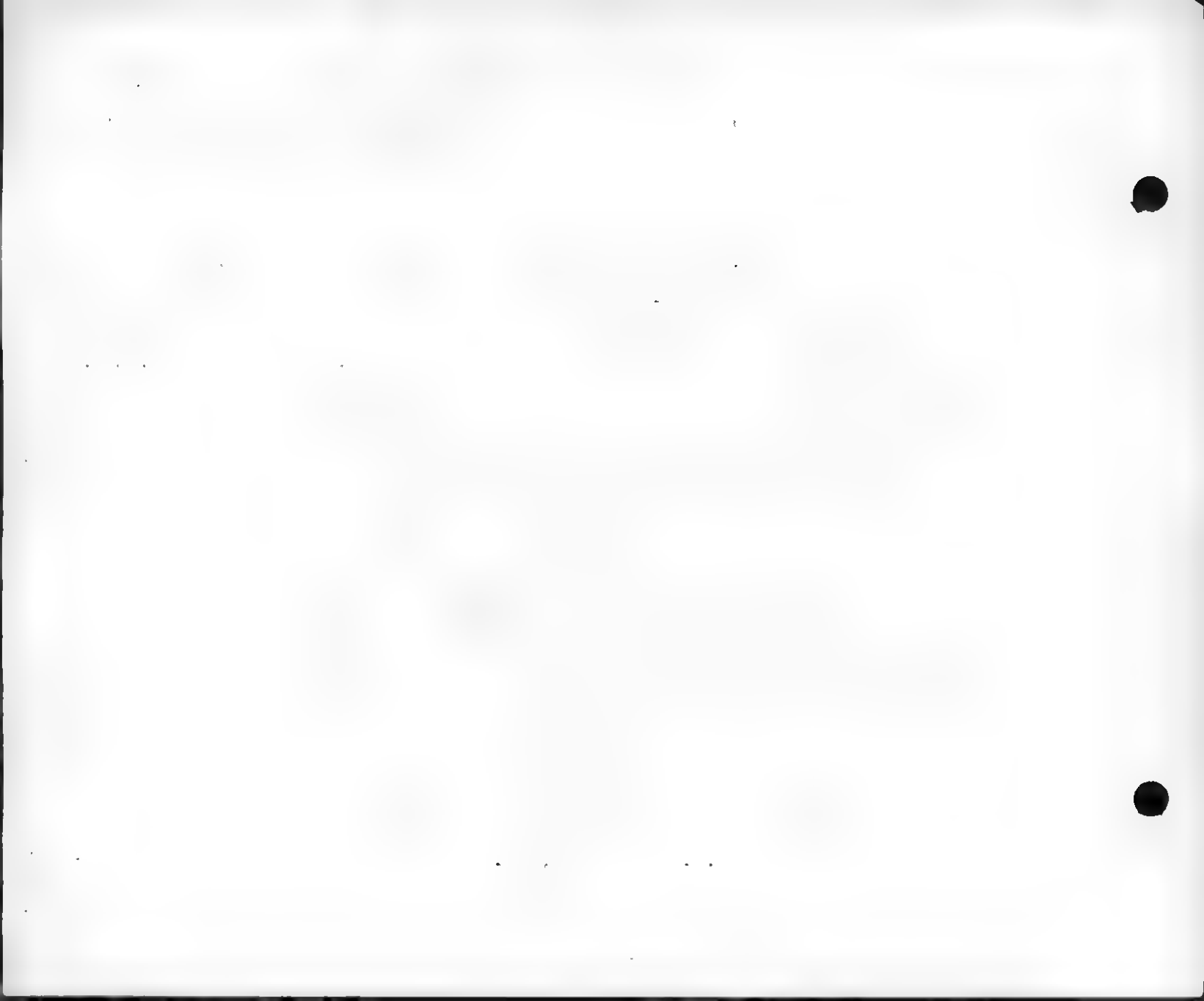
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN TB DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d STREET ADDRESS 2410 Belair Drive	
3 NAME OF DECEASED (Type or print) First Middle Last Patricia Ann Grundmann		4 DATE OF DEATH Month Day Year 12 8 19 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 AGE (In years last birthday) 35 yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY Own Home	11 BIRTHPLACE (State or foreign country) Wisconsin
13 FATHER'S NAME Ermund Narum		14 MOTHER'S MAIDEN NAME Vernice Coda	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO	
17 INFORMANT Charles Grundmann Same as #2 (husband)		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral pulmonary emboli 465 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			INTERVAL BETWEEN ONSET AND DEATH
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 12-9-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, or other disposition Cremation	23b DATE THEREOF 12/12/67	23c NAME OF CHURCH OR CREMATORY Ft. Lincoln	23d LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.
24 FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a REC'D BY REGISTRAR DEC 18 1967	
ADDRESS		25b REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

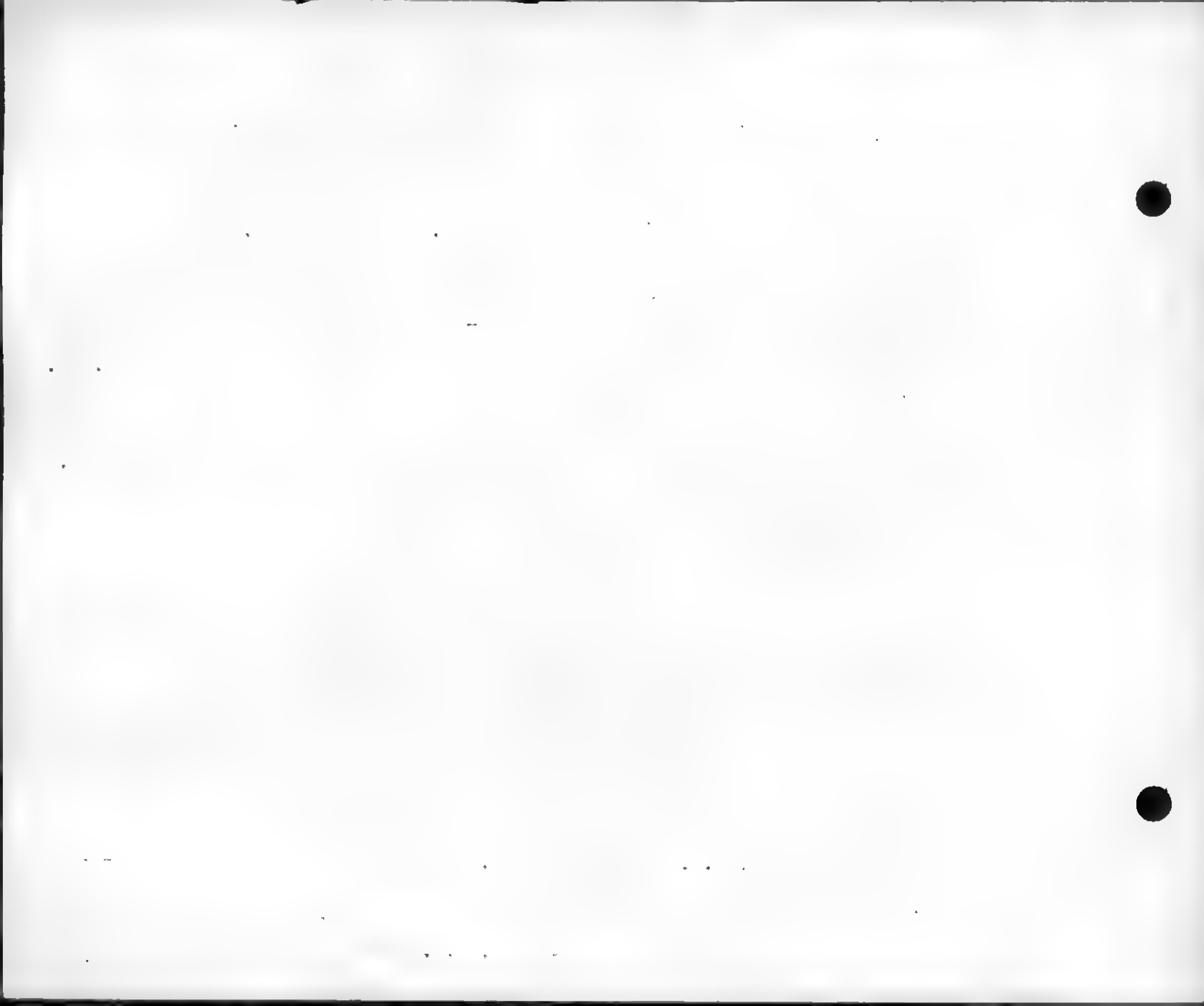
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN It DOA			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 6th. & Chestnut Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ananais Middle Hall Last Hall				4. DATE OF DEATH Month 12 Day 2 Year 1967			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-7-1914		9. AGE (In years last birthday) 53 Yrs	10. IF UNDER 1 YEAR Months 12 Days 2 Hours 19 Min 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Hall				14. MOTHER'S MAIDEN NAME Helen Henson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO		17. INFORMANT Helen Hall		Address 6th & Chestnut Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma DUE TO Carcinoma of pharynx Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe, M.D.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 12-4-67	
EXAMINER'S NAME (Type)		John Kehoe, M.D. Riverdale, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 12-6-1967		23c. NAME OF CEMETERY OR CREMATORY Ebenezer Met.		23d. LOCATION (City or Town) (County) (State) Lanham Maryland	
24. FUNERAL DIRECTOR Washington Funeral Chapel				ADDRESS 475- H St. N.W.		25a. RECEIVED BY REGISTRAR DEC 7 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

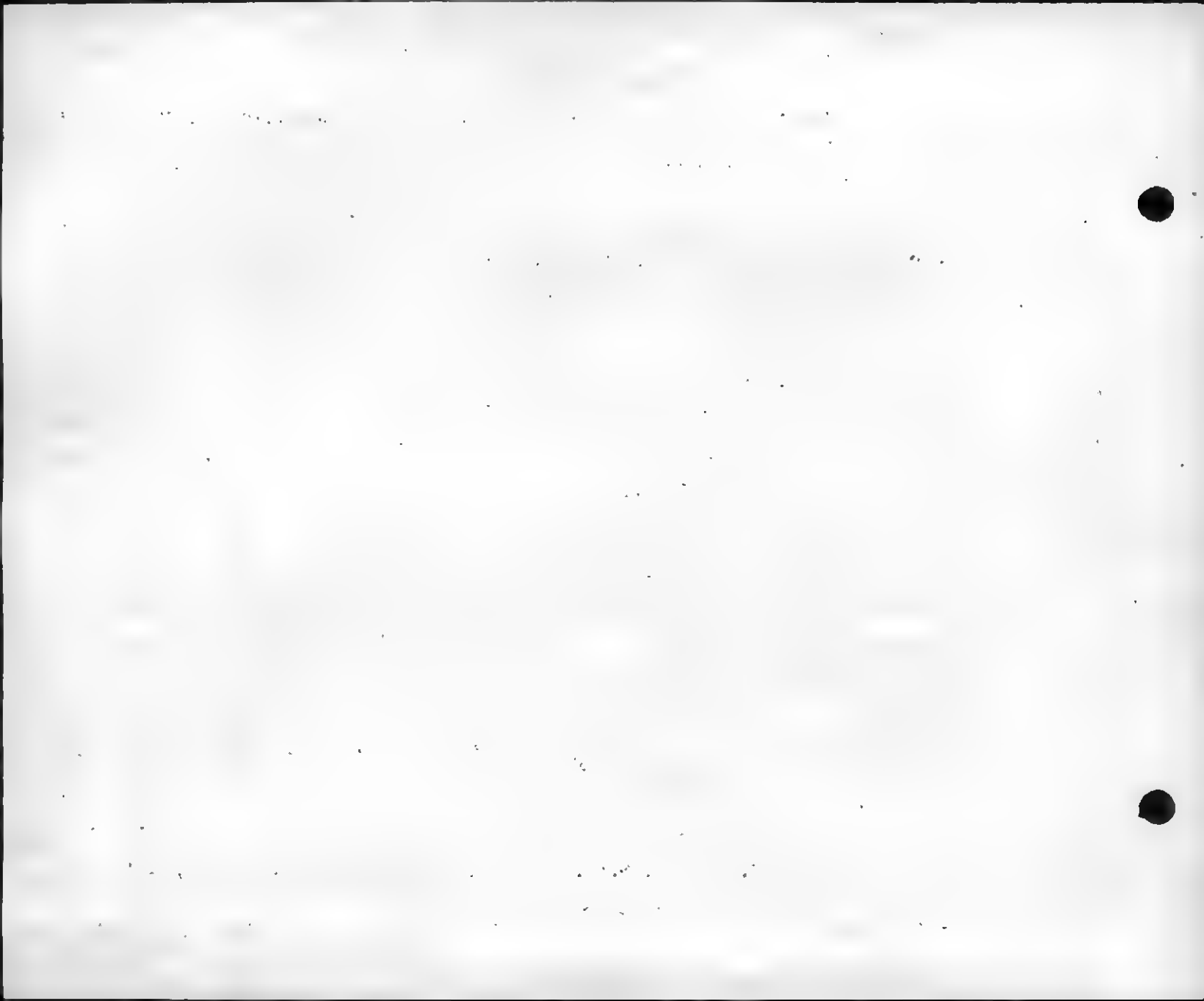
CERTIFICATE OF DEATH

17895

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
Daniel				Hall	December 26, 1967		4:20PM	
3 SEX	4 RACE	5 DATE OF BIRTH			6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	Colored	May 6, 1996			71 YRS	MONTHS DAYS		HOURS MIN
7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
				Prince George's Md				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly		Prince George's Gen'l Hosp						
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b COUNTY	13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER		
						16.1		
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.	17 INFORMANT Address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular Thrombosis</u>								
3300X DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Atherosclerosis</u>								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
<u>Gastrointestinal Bleeding</u>								
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that (a) (this hospital) attended the deceased from <u>12/6</u> , 19 <u>67</u> , to <u>12/26</u> , 19 <u>67</u> , that (a) (we) lost saw the deceased alive on <u>12/26</u> , 19 <u>67</u> , and that in (a) (our) opinion death occurred on the date and hour and from the causes stated above (a) (we) (did) (did not) view the body after death.								
22b SIGNATURE		EDUCATION DEGREE					22c DATE SIGNED	
<u>Edwin J. Jensen, MD</u>							Dec. 29, 1967	
22d PHYSICIAN'S NAME (Type)		22e. ADDRESS						
Edwin J. Jensen, M. D.		Prince Georges General Hospital						
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or town)		(County)		(State)
<u>BURIAL</u>	<u>Jan. 9 - 68</u>	<u>AMAT. Bd. of Md.</u>		<u>Baltimore Md.</u>				
24. FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
				JAN 11 1968		<u>[Signature]</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

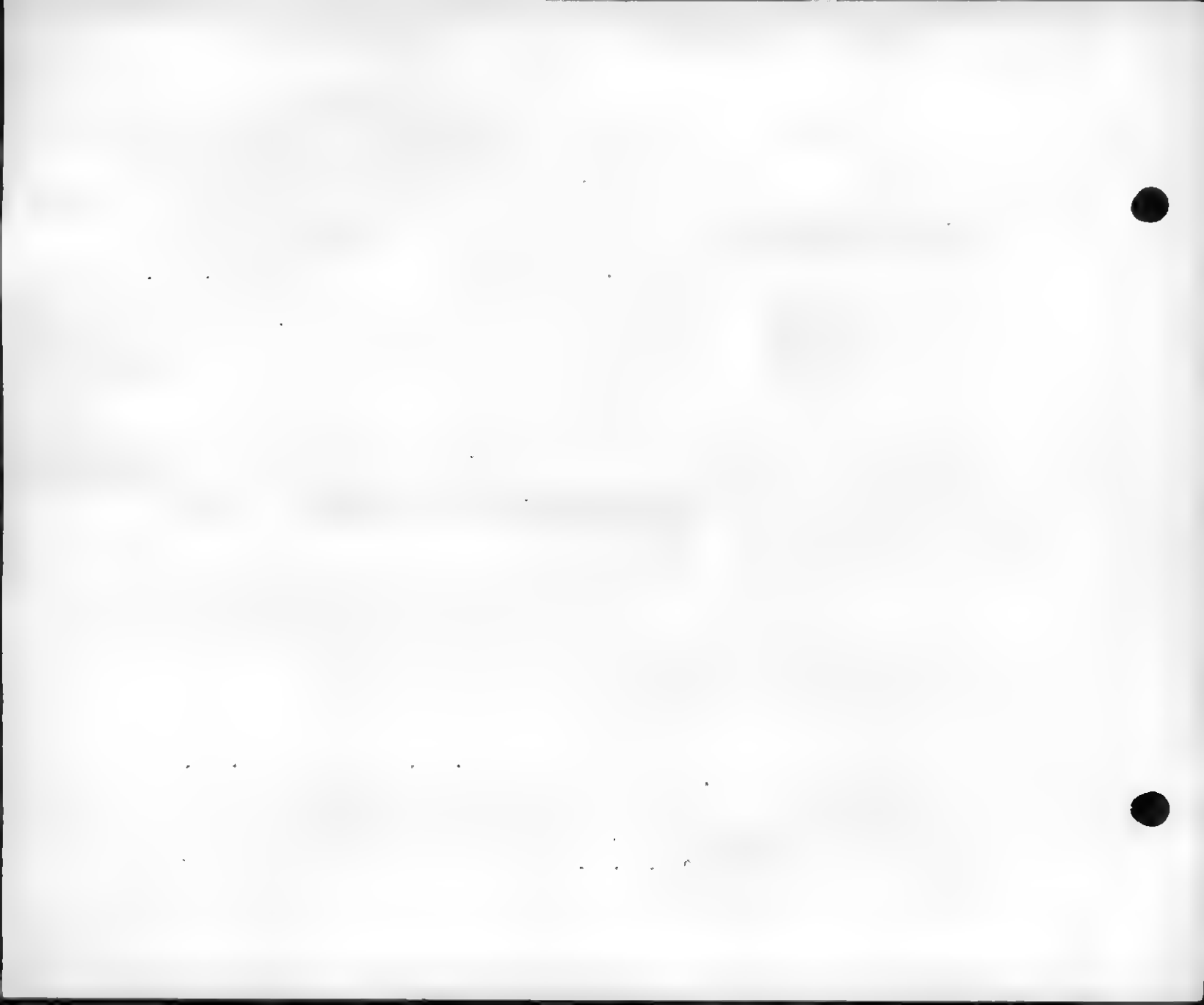
VR A15 (4)
25M 1/67

1
59.5
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17497

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY In 1b 20hrs. 14mins			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				e. STREET ADDRESS 1307 57th Street			
3. NAME OF DECEASED (Type or print) First Middle Last Mary L. Hall				4. DATE OF DEATH Month Day Year Dec. 22, 1967			
5. SEX Female	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-30-1918	9. AGE (In years lost birthday) yrs. 49	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (County & State, or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas J. Dupree				14. MOTHER'S MAIDEN NAME Addie New			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Detroit Hall - Husband - same address D			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Abdominal carcinomatosis from cancer of the breast DUE TO breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from Dec. 21, 1967 , to Dec. 22, 1967 , that he (we) last saw the deceased alive on Dec. 22, 1967 , and that death occurred at 8:15 AM , from causes and on the date stated above.							
22a. SIGNATURE Till Bergemann				22b. DATE SIGNED 12/22/67		22c. PHYSICIAN'S NAME (Type) Till Bergemann, M. D.	
22d. ADDRESS Prince Georges General Hospital				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 12-27-67		23c. NAME OF CEMETERY OR CREMATORY Harmony mem Park		23d. LOCATION (City or Town) (County) (State) Highland Park Md.	
24. FUNERAL DIRECTOR H. B. Washington				25a. REC'D BY REGISTRAR 4925 Deane Ave NE		25b. REGISTRAR'S SIGNATURE DATE JAN 2 1968	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

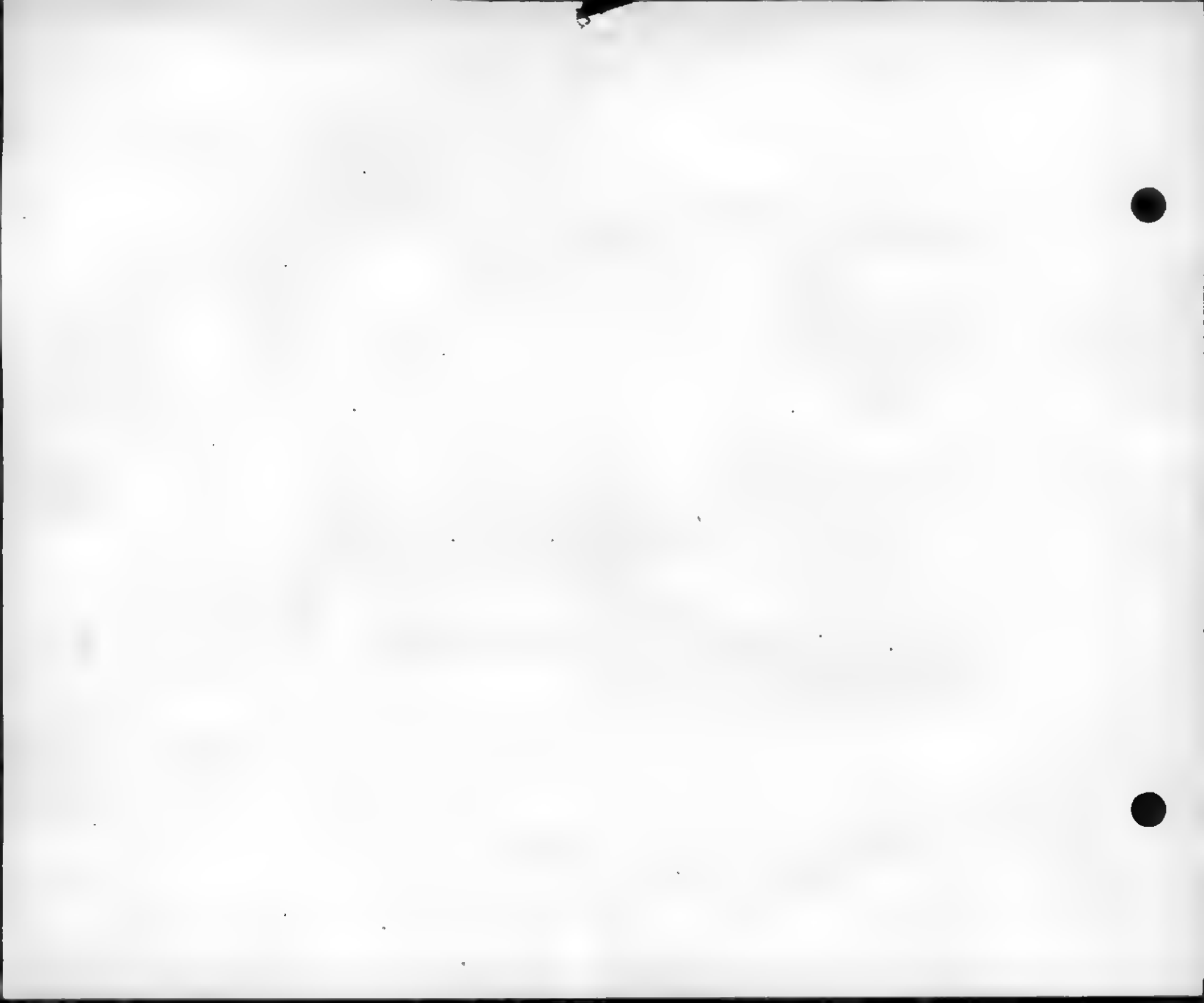
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 4 and 5) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17498

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE VIRGINIA b COUNTY FAIRFAX	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews AFB		c LENGTH OF STAY IN 1b 101 Days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Malcolm Grow USAF Hospital		d STREET ADDRESS 9032 PIXIE CT	
3 NAME OF DECEASED (Type or print) ALBERT GEORGE HAMEL		4 DATE OF DEATH Month December Day 18 Year 1967	
5 SEX Male	6 COLOR OR RACE Cauc	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 30 Jan 18
9 AGE (In years last birthday) 49 yrs		10 IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	11 IF UNDER 24 HRS Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) AIR FORCE		10b. KIND OF BUSINESS OR INDUSTRY Military	
11 BIRTHPLACE (County & State, or foreign country) ROSCOE, NEW YORK		12. CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME ALBERT V. HAMEL		14 MOTHER'S MAIDEN NAME GLADYS E. MILLER	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes 1941-1967		16 SOCIAL SECURITY NO 121-01-3033	
17 INFORMANT Wife		Address Same as item #2	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Severe Bilateral pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Bronchogenic carcinoma right DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prob. brain metastases & Renal metastases			INTERVAL BETWEEN ONSET AND DEATH 3 weeks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8 Sep 1967 to 18 Dec 1967 , that (I) (we) last saw the deceased alive on 18 Dec 1967 , and that death occurred at 2:45 PM from causes and on the date stated above			
22a. SIGNATURE Frank A. Camp M.D.		22b. DATE SIGNED 18 Dec 67	
22c. PHYSICIAN'S NAME (Type) FRANK A. CAMP, MAJ USAF MC		22d. ADDRESS MALCOLM GROW USAF HOSP ANDREWS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/21/67	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem	23d. LOCATION (City or Town) (County) (State) Arlington Virginia
24. FUNERAL DIRECTOR Falls Church Funeral Home, Falls Church, Va.		25a. REC'D BY REGISTRAR DATE DEC 26 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17491

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>P.G.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>				c. LENGTH OF STAY IN 1b <u>DOA</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cottage City</u>				d. STREET ADDRESS <u>4106 Cottage Terr.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>J.J.</u> Last <u>HAMILTON</u>				4. DATE OF DEATH Month <u>December</u> Day <u>4</u> Year <u>1967</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 8 1900</u>	
9. AGE (In years lost birthday) <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Engineer</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Hamilton</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Duffy</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) <u>Yes</u> <u>WWII</u>				16. SOCIAL SECURITY NO <u>111 07 1305 AB</u>		17. INFORMANT (Son) <u>Alexander W. Hamilton</u> Address <u>Riverside Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Arteriosclerotic Heart disease & coronary insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Arteriosclerotic Heart disease & coronary insufficiency</u> (c) <u>coronary insufficiency</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 minutes</u> <u>4 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 12, 1967</u> , to <u>Dec</u> , 1967, that (I) (we) last saw the deceased alive on <u>12/25</u> 1967, and that death occurred at <u>2:25 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>12/4/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Hubert W. Brady M.D.</u>	
22d. ADDRESS <u>11161 N.H. Ave. Silver Spring Md</u>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-7-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>		23d. LOCATION (City or Town) (County) (State) <u>Southland P.G. Md.</u>	
24. FUNERAL DIRECTOR <u>Nalley Funeral Home</u>				25a. REC'D BY REGISTRAR <u>DEC 11 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

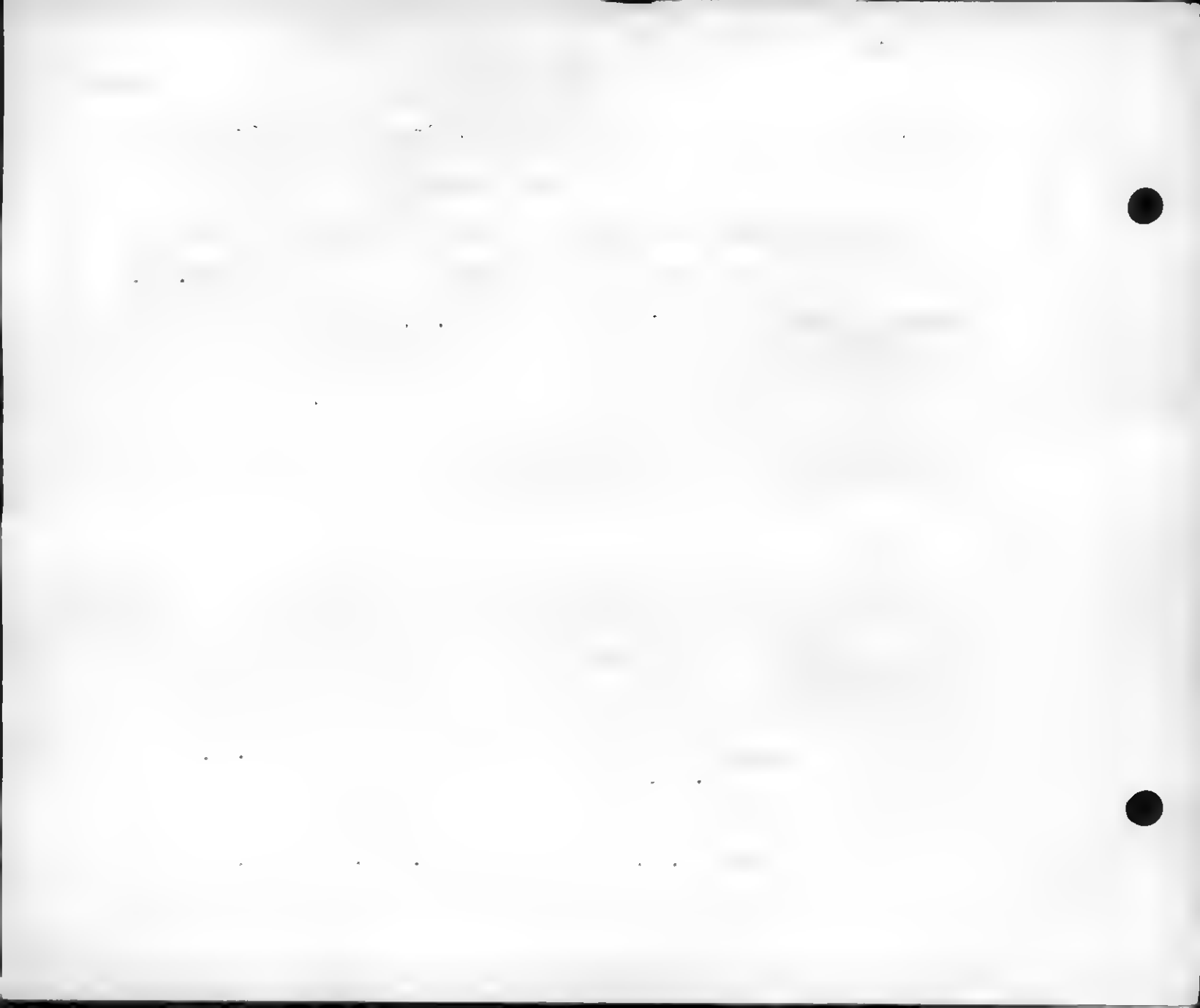
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY Prince Georges b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c LENGTH OF STAY IN 1b 1 hr & 30 mins d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Prince Georges c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt d STREET ADDRESS 12 J Ridge Road e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Pauline First Middle Last Hanyok		4 DATE OF DEATH Month Day Year Dec 11 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Jan. 23, 1894
9 AGE (In years last birthday) 73 yrs		10 UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) AUSTRIA		12 CITIZEN OF WHAT COUNTRY? U.S.	
13 FATHER'S NAME JOSEPH. KEBBLISH		14 MOTHER'S MAIDEN NAME MARY PATRICK	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. NONE	
17 INFORMANT MRS IRENE JANOSKO		Address SAME AS #2	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest DUE TO (b) Coronary Thrombosis DUE TO (c) Coronary Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 hours 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (1) the hospital attended the deceased from JUNE , 1957, to Dec. 11, 1967 , that (1) was last saw the deceased alive on Dec. 11, 1967 , and that death occurred at 10:30 M , from causes and on the date stated above.			
22a SIGNATURE Hans Wodak		22b DATE SIGNED Dec. 11, 1967	
22c PHYSICIAN'S NAME (Type) Hans Wodak, M. D.		22d ADDRESS Prof. Bldg. Greenbelt, Maryland 20770	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	12-14-1967	ST. JOHNS BYZANTINE	BARNESBORO, PENNA.
24 FUNERAL DIRECTOR W. W. Chambers, Riverside Md.		25a REC'D BY REGISTRAR	25b REGISTRAR'S SIGNATURE
		DATE DEC 18 1967	John L. Jones

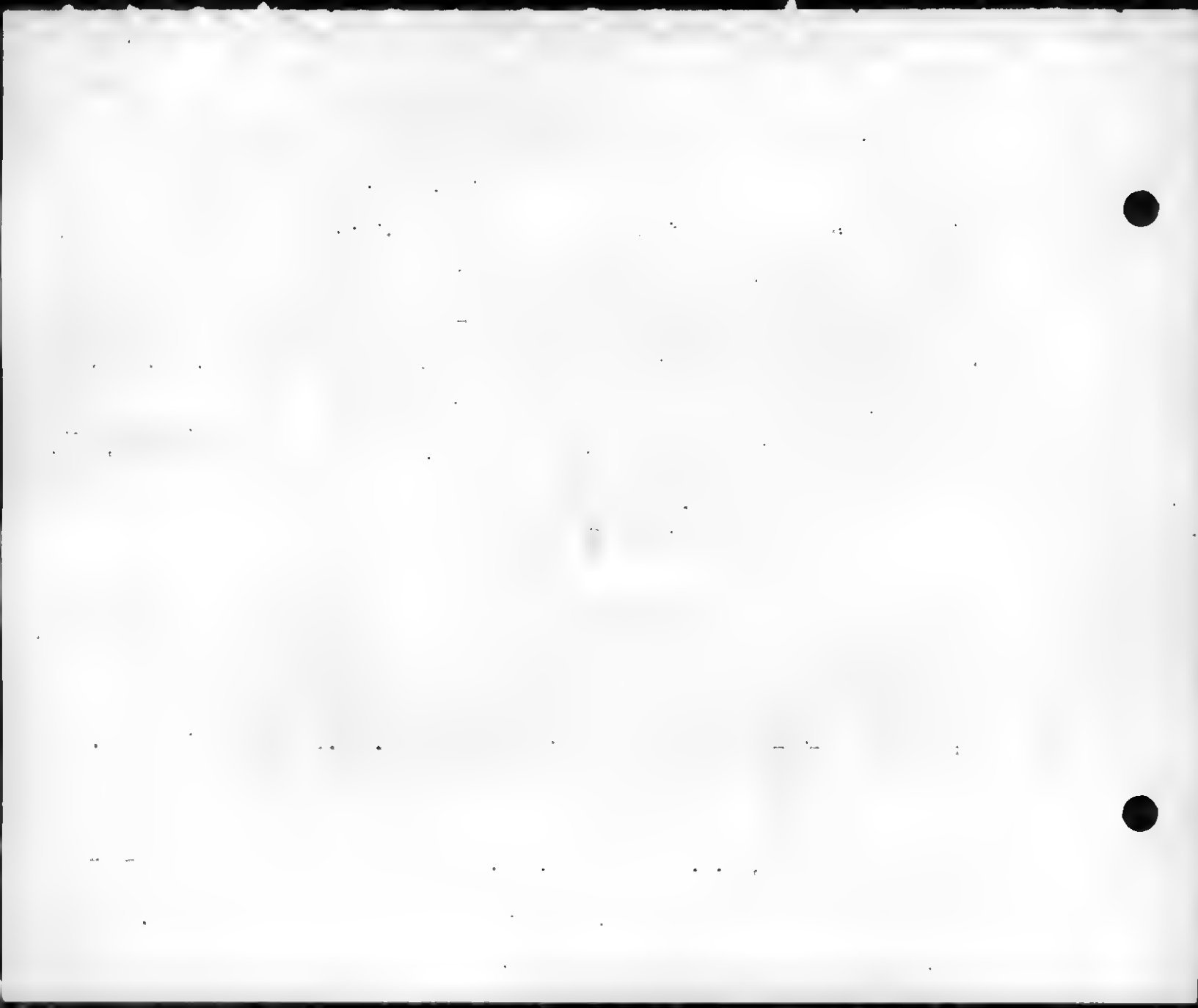


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, a funeral director should be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN ID <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg</u> d. STREET ADDRESS <u>4000 52nd. Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George Marshall Harris</u>		4. DATE OF DEATH Month <u>12</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-19-1946</u>
9. AGE (In years last birthday) <u>21</u> yrs.		10. IF UNDER 1 YEAR Months <u>12</u> Days <u>23</u> Hours <u>11</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Apprentice</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Machinist</u>	
11. BIRTHPLACE (State or foreign country) <u>Prince George Co, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George M. Harris Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Mary Oniel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>217 44 3937</u>	
17. INFORMANT <u>George N. Harris Jr</u>		1000001 Menlo Ave. <u>Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laceration of brain</u> DUE TO <u>Trauma - auto accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in car involved in a collision</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>1:51am</u> <u>12-23-1967</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>3800 block 38th. St., Cottage City, Md.</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Kehoe</u> EXAMINER'S NAME (Type) <u>John Kehoe, M.D.</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Riverdale, Md.</u>	
22. DATE SIGNED <u>12-26-67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/27/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		23d. LOCATION (City, town or county) (State) <u>Colmar Manor P.G. Md.</u>	
24. FUNERAL DIRECTOR <u>Francis Gasch's Sons</u>		ADDRESS <u>Hyattsville, Md.</u>	
25a. REC'D BY REGISTRAR DATE <u>JAN 2 1968</u>		25b. REGISTRAR'S SIGNATURE <u>William J. Smith</u>	



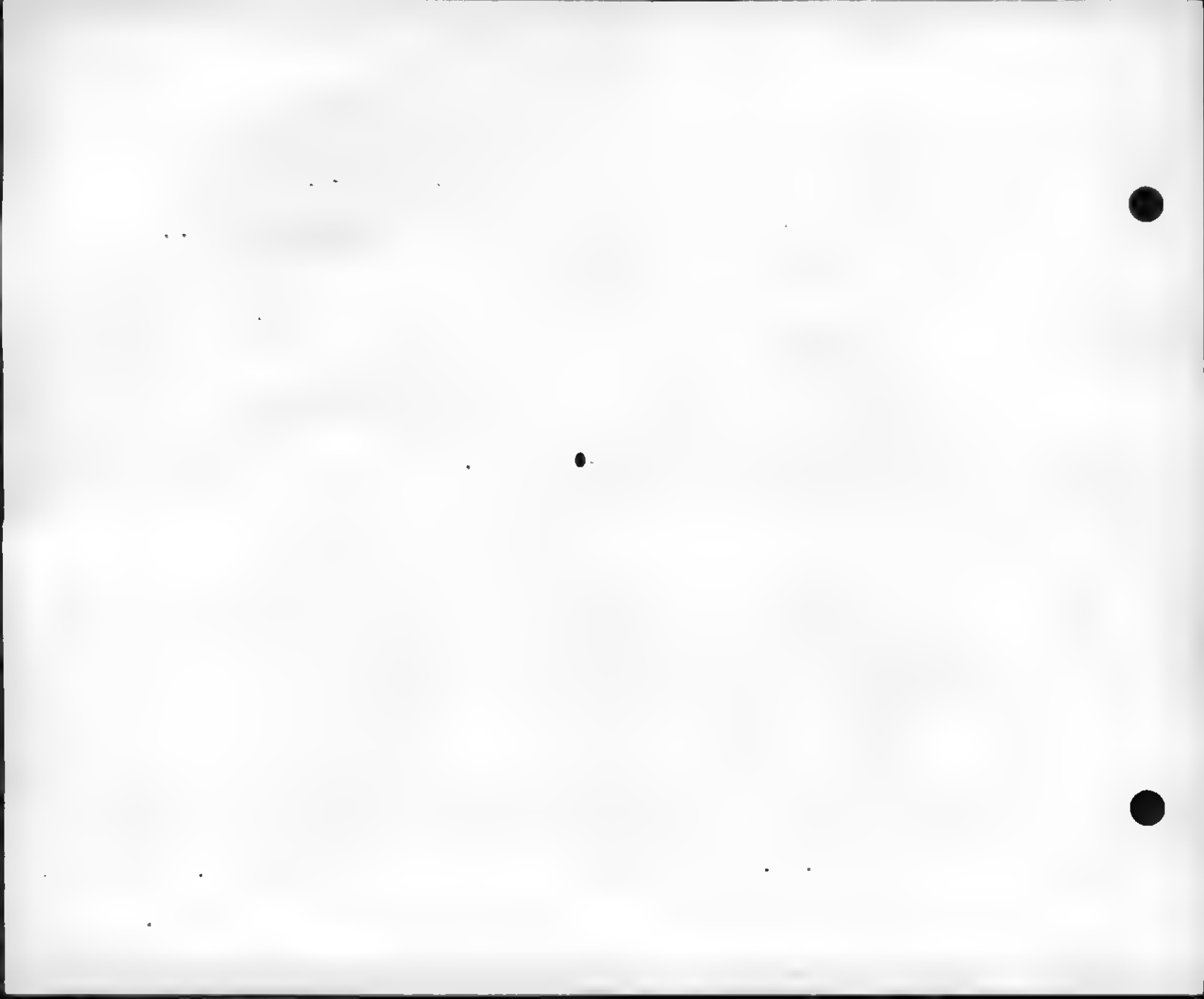
1
495
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17504

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Md		c. LENGTH OF STAY IN 1b 55 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier, Md 20322			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital				d. STREET ADDRESS 2505 Queens Chapel Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elsie H. Hays				4. DATE OF DEATH December 13, 1967			
5. SEX F.	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/4/82	9. AGE (In years last birthday) 85 yrs	10. UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Not given				14. MOTHER'S MAIDEN NAME Katherine Stewart			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 579-12-0711		17. INFORMANT Mrs. James Eaton, Hyattsville			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GASTRIC CARCINOMA 15 IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-25, 1967, to 12-18, 1967, that (I) (we) last saw the deceased alive on 12-18, 1967, and that death occurred at 6 P.M. from causes on and on the date stated above.							
22a. SIGNATURE C. J. Houmann		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 12-18-67			
22c. PHYSICIAN'S NAME (Type) Dr. C.J. Houmann		22d. ADDRESS 4400 Queensbury Rd. Riverdale,					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 12/22/67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Md.	
24. FUNERAL DIRECTOR The S. H. Hince Co 2901-14th St. N.W. D.C.				25a. REC'D BY REGISTRAR DATE DEC 21 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



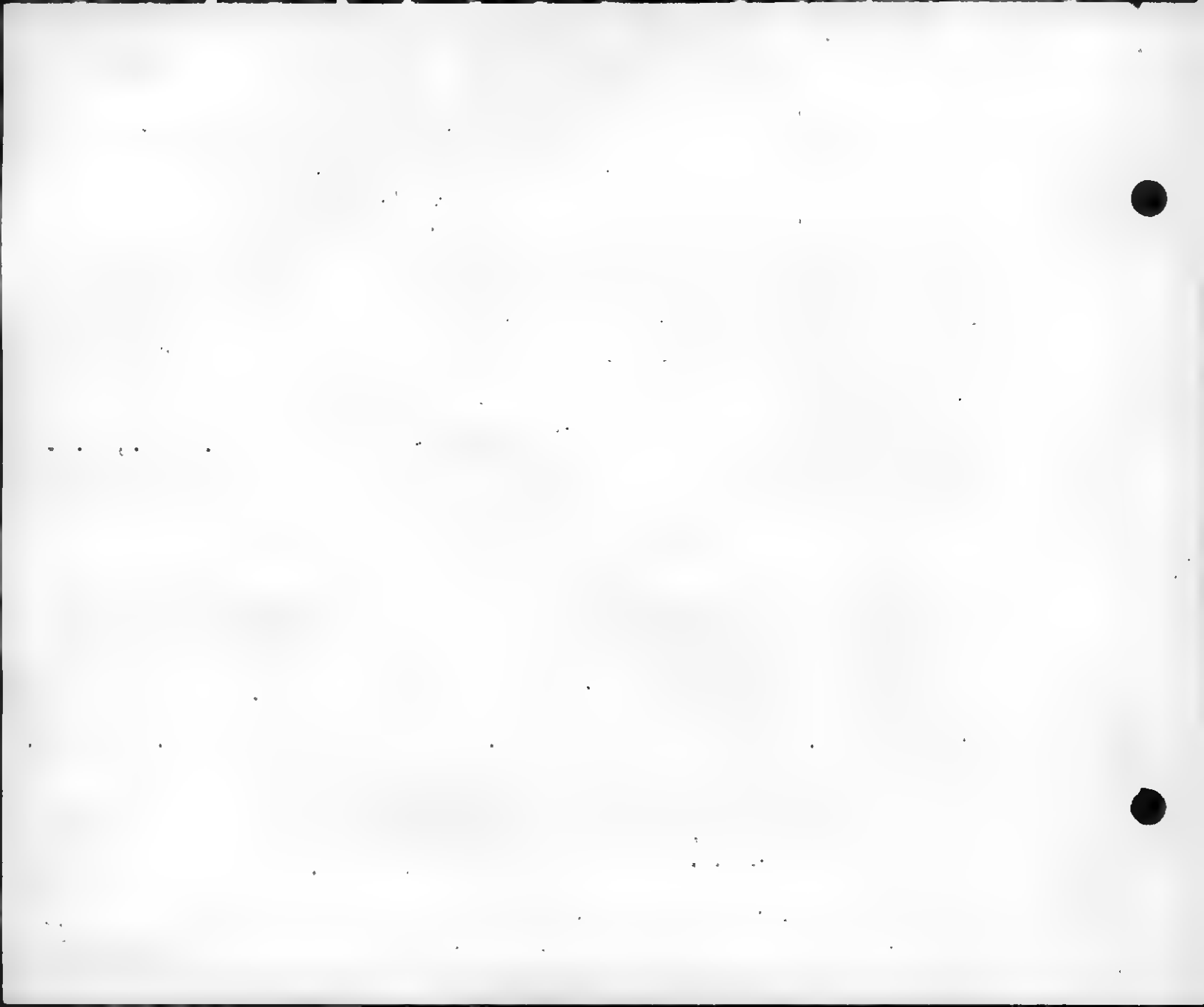
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate must be executed within 24 hours after death. If any delay is necessary, the certificate must be executed "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 27 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's Hospital		d. STREET ADDRESS Trump's Hill Road Rt. 1 Box 4580		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Laura Christine Henderson		4. DATE OF DEATH Month Day Year December 27 19 67			
5. SEX female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 2, 1898	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -- --		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Edward Clark		12. CITIZEN OF WHAT COUNTRY? USA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. -- --		17. INFORMANT Marie Morris 3989 Mass. Ave., S.E. Daughter	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral pulmonary emboli DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Immobilization for fracture of right hip DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH unknown { 4 months 25 days
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in car involved in collision.			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 5PM Aug. 2 19 67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Car.	
		20f. (City or town) Groom		(County) P.G.	
				(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 12-28-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		Address (Street, City, Town or County) Bivendale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-30-67		23c. NAME OF CEMETERY OR CREMATORY Union Methodist Cem.	
				23d. LOCATION (City, town or county) (State) Upper Marlboro, Md.	
FUNERAL DIRECTOR Rollins Funeral Home, Inc.		ADDRESS 4339 Hunt Pl. N.E. Washington, D.C.		25a. REC'D BY REG. STRAR JAN 3 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

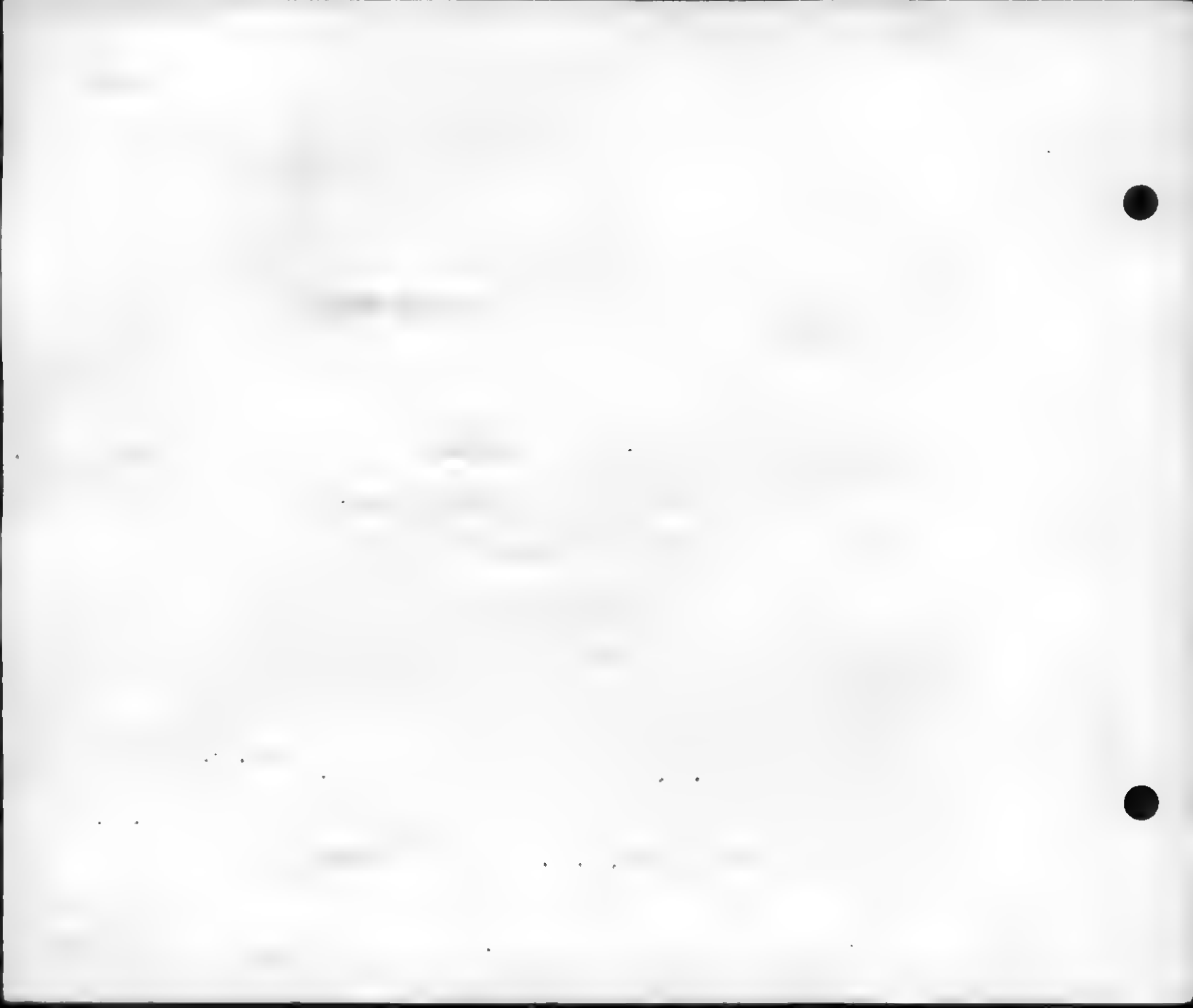
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md b. COUNTY Pro Geo	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN 1b 4 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e STREET ADDRESS 8116 Sherrill st	
3 NAME OF DECEASED (Type or print) First William Middle Wallace Last Hensler IV		4 DATE OF DEATH Dec 4, 1967	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Aug. 31, 1966
9 AGE (In years last birthday) 1 yrs		10 IF UNDER 1 YEAR Months 4 Days 4	11 IF UNDER 24 HRS Hours 4 Min 19
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Prince Georges Md		12 CITIZEN OF WHAT COUNTRY? U S A	
13 FATHER'S NAME William Wallace Hensler III		14 MOTHER'S MAIDEN NAME Evelyn Louise Lanier	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) --		16 SOCIAL SECURITY NO --	
17 INFORMANT William Wallace Hensler III Address Palmer Mark Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Perforated acute duodenal ulcer 5410 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Peritonitis DUE TO (c) Pleural effusions			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (he) (this hospital) attended the deceased from Nov. 30, 1967 , to Dec. 4, 1967 , that (he) (we) last saw the deceased alive on Dec. 4, 1967 , and that death occurred at 5 A.M. from causes and on the date stated above.			
22a. SIGNATURE Bernardo Alvarado, M. D.		22b. DATE SIGNED Dec. 5, 1967	
22c. PHYSICIAN'S NAME (Type) Prince Georges General Hospital		22d ADDRESS Prince Georges General Hospital	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF Dec 6, 1967	23c NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	23d LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.
24 FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a REC'D BY REGISTRAR DEC 11 1967	25b REGISTRAR'S SIGNATURE Charles Judge



1

501

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 13 Film 6886 1/3/68 kr

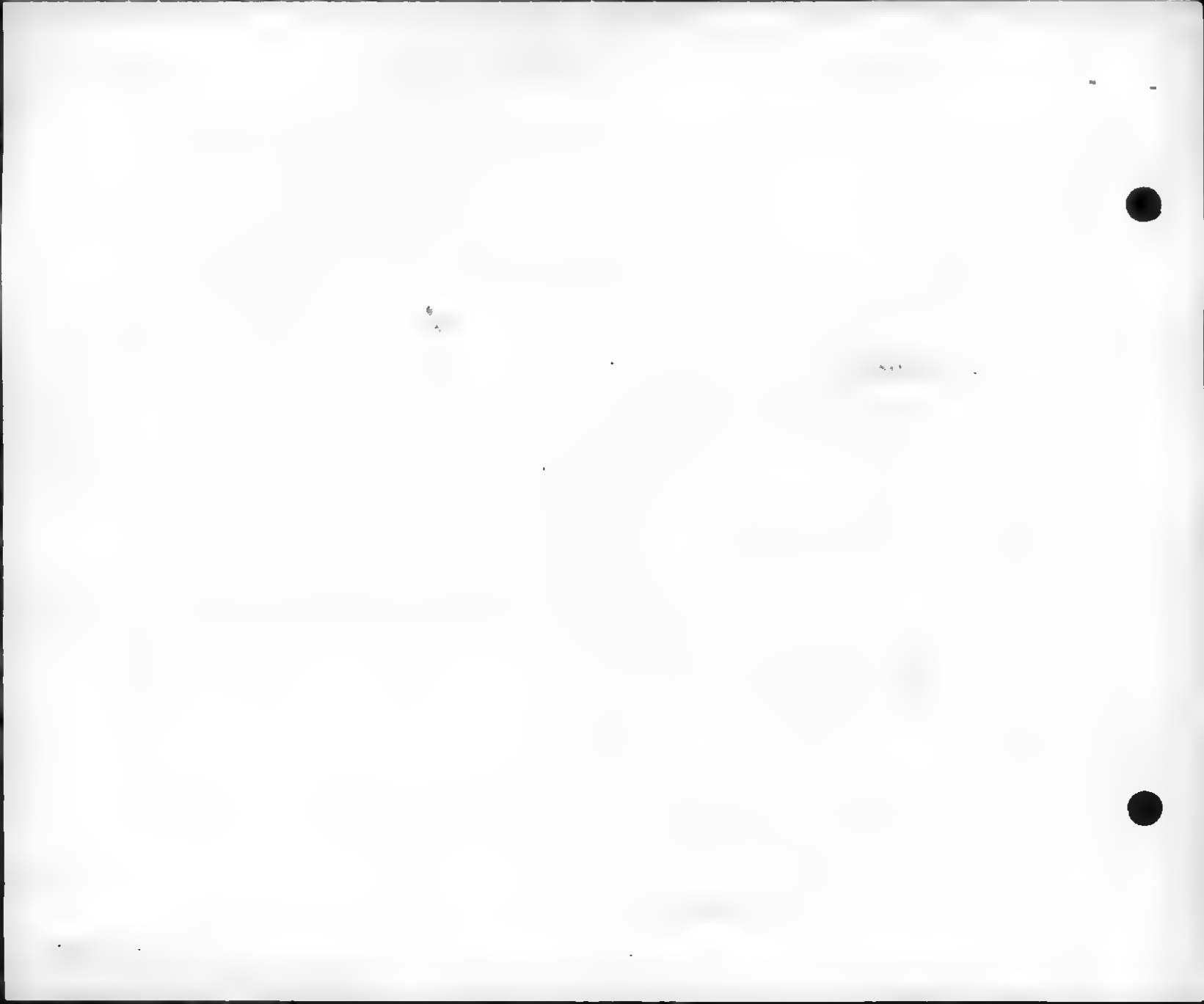
CERTIFICATE OF DEATH

11507

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>DR. GEORGE'S</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Dr. George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Pine View Gardens Health Care Center</u>		d. STREET ADDRESS <u>6806 Colonial Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>E.</u> Last <u>HEUSEL</u>		4. DATE OF DEATH Month <u>DEC.</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-24-1883</u>
9. AGE (n years last birthday) <u>84</u> yrs		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during part of working life even if retired) <u>LABELING CANS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FACTORY</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Heusel Mitchell</u>		14. MOTHER'S MAIDEN NAME <u>Maria Wilkins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or not known) <u>NO</u>		16. SOCIAL SECURITY NO. <u>40-03-22140</u>	
17. INFORMANT <u>Lot 29 RFD Box 4311 Mrs Margaret Grimes Upper Marlboro Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>ARTERIOSCLEROTIC CARDIAC DISEASE 3 YRS.</u> DUE TO (c) <u>SENILE THROMBOTIC SYNDROME</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/10</u> , 19 <u>67</u> , to <u>12-29</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12-29</u> , 19 <u>67</u> , and that death occurred at <u>4:30 PM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Alfred R. Lapin</u>		22b. DATE SIGNED <u>12-29-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN MD</u>		22d. ADDRESS <u>CLINTON, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>1-3-68</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BAYVIEW CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>Jersey City, N.J.</u>
24. FUNERAL DIRECTOR <u>The North Funeral Home, Jersey, N.J.</u>		25a. REC'D BY REGISTRAR <u>JAN 3 1968</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11503

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Washington, D.C.</u> b. COUNTY <u>C</u>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Huntsville Nursing Home</u>				d. STREET ADDRESS <u>1117 48th Pl. N.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Maud</u> Last <u>Hill</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>27</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 1884</u>	9. AGE (In years last birthday) <u>83</u> yrs	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pro gangrene cerebral infarction</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>hypertensoid arterio-sclerosis</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sublethal cerebral infarction infarcts</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12/17</u> , 19 <u>67</u> , to <u>12/27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/26</u> , 19 <u>67</u> , and that death occurred at <u>2:10</u> P.M. from causes and on the date stated above.							
22a. SIGNATURE <u>Edw. J. Hill</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/27/67</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>1-2-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hoodlawn</u>		23d. LOCATION (City or Town) (County) (State) <u>Bonnycastle, S.D. S.C.</u>	
24. FUNERAL DIRECTOR <u>Edmonson Funeral Service</u>				ADDRESS <u>909 6th St. N.W.</u>		25a. REC'D BY REGISTRAR <u>JAN 3 1968</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17509

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE D.C. b COUNTY C	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c LENGTH OF STAY IN 1b 6 mo.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		e STREET ADDRESS 914 New York Ave., N.W.	
3 NAME OF DECEASED (Type or print) First Martin Middle A. Last Hofmann		4 DATE OF DEATH Month December Day 23 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9/19/1912
9a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		9b KIND OF BUSINESS OR INDUSTRY - - -	9c AGE (In years last birthday) 55 yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b KIND OF BUSINESS OR INDUSTRY - - -	11 BIRTHPLACE (County & State, or foreign country) Washington, D.C.
12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME Alphonsus Hofmann	
14 MOTHER'S MAIDEN NAME Elizabeth Dilhl		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16 SOCIAL SECURITY NO 579-03-3768		17 INFORMANT (Decedent)	
18a CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, acute (clinical) DUE TO (b) sudden Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) pulmonary tuberculosis, far advanced		INTERVAL BETWEEN ONSET AND DEATH 7yrs., 8mos.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic alcoholism.		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (X) (this hospital) attended the deceased from 6/23 , 19 67 , to 12/23 , 19 67 , that (X) (we) last saw the deceased alive on 12/23 , 19 67 , and that death occurred at 5:40PM , from causes and on the date stated above.			
22a SIGNATURE Moe Weiss		22b DATE SIGNED 12/23/67	
22c PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22d ADDRESS Glenn Dale Hospital Glenn Dale, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) removal	23b DATE THEREOF 1/4/68	23c NAME OF CEMETERY OR CREMATORY NATIONAL CEMETERY	23d LOCATION (City or Town) (County) (State) Washington, D.C.
24 FUNERAL DIRECTOR Charles J. Goff		25a REC'D BY REGISTRAR JAN 5 1968	
25b REGISTRAR'S SIGNATURE Charles J. Goff			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

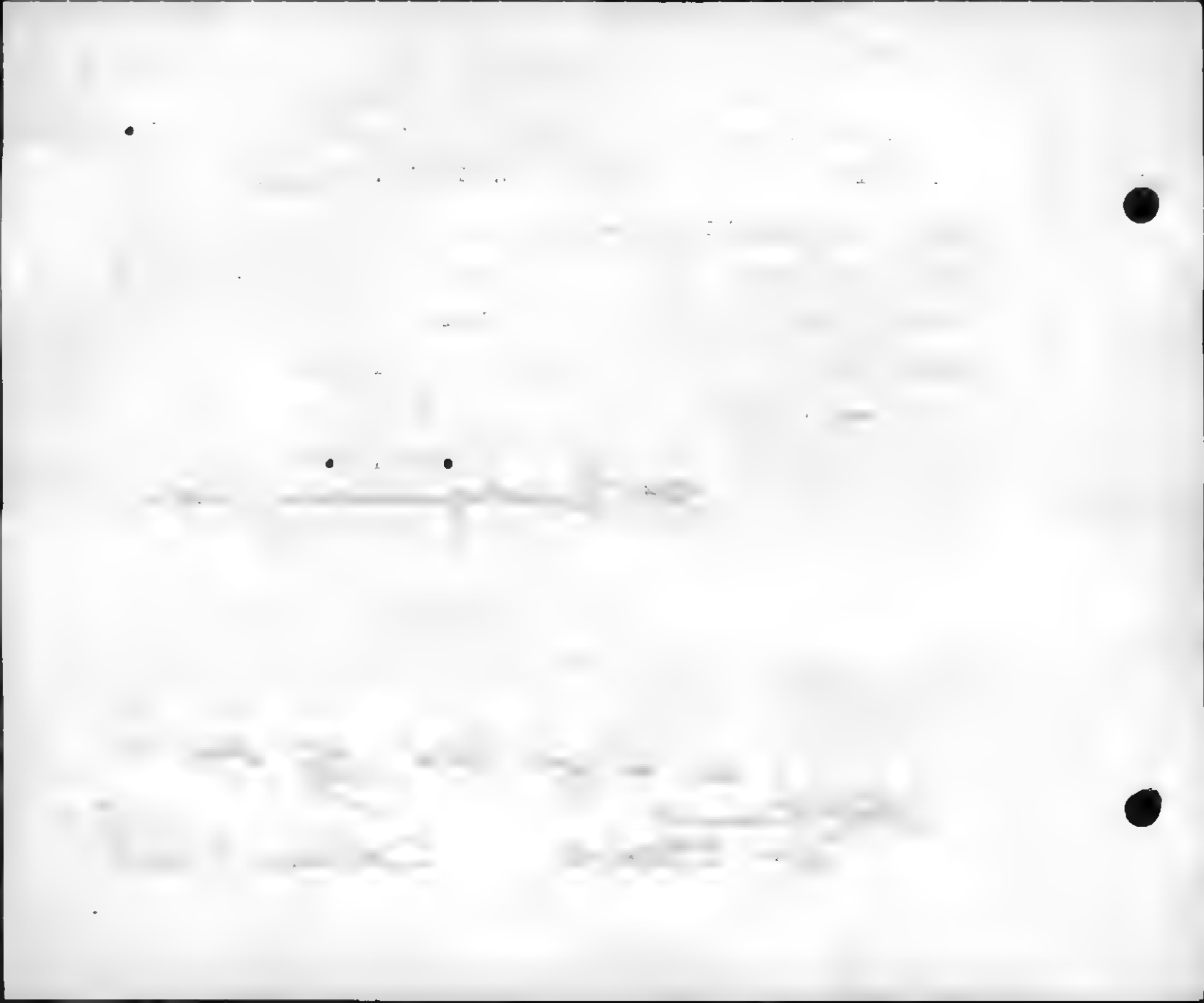
VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11510

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN ID 2 days 9 hrs. & 10 Mins. Greenbelt	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		d. STREET ADDRESS 48 Lakeside Drive	
3. NAME OF DECEASED (Type or print) First Bessie Middle Hooppaw Last Hooppaw		4. DATE OF DEATH Month 12 Day 05 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/13/83
9. AGE (In years last birthday) yrs 84		10. IF UNDER 1 YEAR Months Days Hours Mm	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired draftman		10b. KIND OF BUSINESS OR INDUSTRY U S Government	
11. BIRTHPLACE (County & State, or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William R. Hooppaw		14. MOTHER'S MAIDEN NAME Cagle, Lucy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 578 58 5377	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per immediate (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) Chronic Bronchopneumonia, left		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov 4 , 19 67 to Dec 5 , 19 67 , that (I) (we) last saw the deceased alive on Dec 4 , 19 67 , and that death occurred at 4:30 M, from causes and on the date stated above			
22a. SIGNATURE W.L. Etienne		22b. DATE SIGNED 12/5/67	
22c. PHYSICIAN'S NAME (Type) W.L. ETIENNE		22d. ADDRESS College Park	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 12/8/67	23c. NAME OF BURIAL OR CREMATORY Ft. Lincoln	23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md		25a. REC'D BY REGISTRAR DEC 11 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

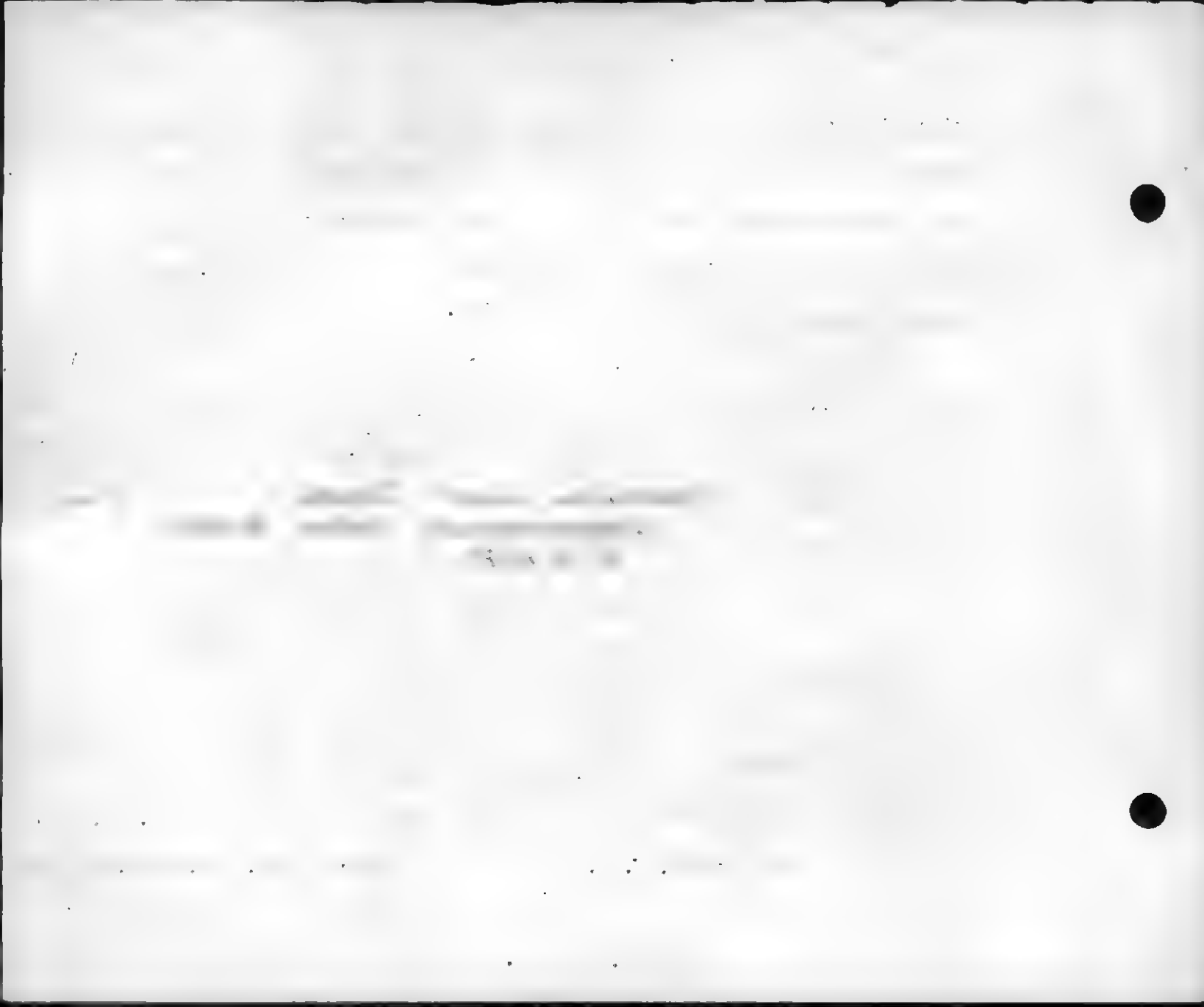


TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN ID 22 hours			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital				e. STREET ADDRESS 6614 Ian Street			
3. NAME OF DECEASED (Type or print) First Middle Last Michelle Hopkins				4. DATE OF DEATH Month Day Year Dec. 10, 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 10, 1967	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		9b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME JOHN G. HOPKINS II				14. MOTHER'S MAIDEN NAME DIANE FONCANNON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT #13- 6614 Ian St. New Carrollton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGENITAL HEART DISEASE: DUE TO INTERVENTRICULAR SEPTAL DEFECT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) I.C.H.F. (c)							INTERVAL BETWEEN ONSET AND DEATH 3 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 9, 1967 to Dec. 10, 1967 , that (I) (not) last saw the deceased alive on Dec 10 19 67 , and that death occurred at 10:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE John Perkins				22b. DATE SIGNED Dec. 10, 1967		22c. PHYSICIAN'S NAME (Type) John Perkins, M. D.	
22d. ADDRESS 6201 Riverdale Road, Riverdale, Maryland				22e. REC'D BY REGISTRAR			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-13-67		23c. NAME OF CEMETERY OR CREMATORY ADDISON CHURCH CEMETERY		23d. LOCATION (City, town or county) (State) SEAT Pleasant, MD	
24. FUNERAL DIRECTOR J. Wm Lee & Sons, 300 4th St. N.E., WASH. DC.				25a. REGISTRAR'S SIGNATURE William Lee			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

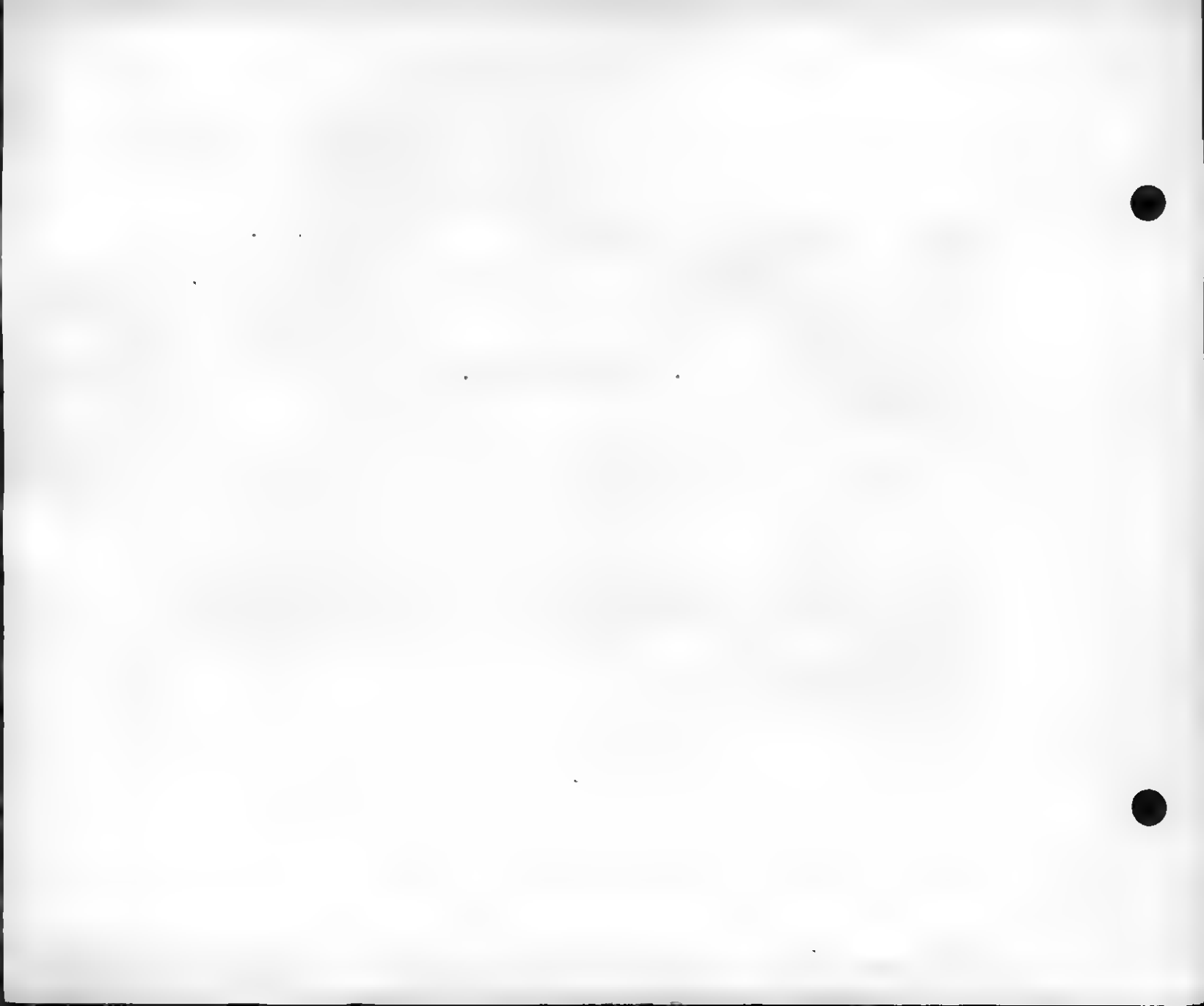
VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17512

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 5700 Nash St., N.E.	
3. NAME OF DECEASED (Type or print) First Middle Last Fletcher Horne		4. DATE OF DEATH Month Day Year Dec 9 1967	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-23-07
9. AGE (In years lost birthday) 60 yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse Attendant		10b. KIND OF BUSINESS OR INDUSTRY St. Elizabeth's Hosp.	
11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Horne		14. MOTHER'S MAIDEN NAME Katie Henry	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 5-78-07-228		16. SOCIAL SECURITY NO. 5-78-07-228	
17. INFORMANT Dillie Horne-5700 Nash Street, NE - Wife		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive pulmonary emboli. DUE TO bilateral. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Severe fatty metamorphosis of liver. DUE TO (c) Hypertensive heart disease.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-8 , 19 67 , to 12-9 , 19 67 , that () (we) last saw the deceased alive on 12-9 , 19 67 , and that death occurred at 3P. M, from causes and on the date stated above.			
22a. SIGNATURE Hernandez		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) T. J. Hernandez, MD		22d. ADDRESS Prince George's Hospital, Cheverly	
23a. BURIAL, CREMATION, REMOVAL (Specify) 12-14-67		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY HARMONY MEMORIAL PARK		23d. LOCATION (City or town) (County) (State) PRINCE GEORGE CO., MARYLAND	
24. FUNERAL DIRECTOR John T. Rhodes		25a. REC'D BY REGISTRAR DEC 18 1967	
ADDRESS 3015 12th St. N.E.		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT.

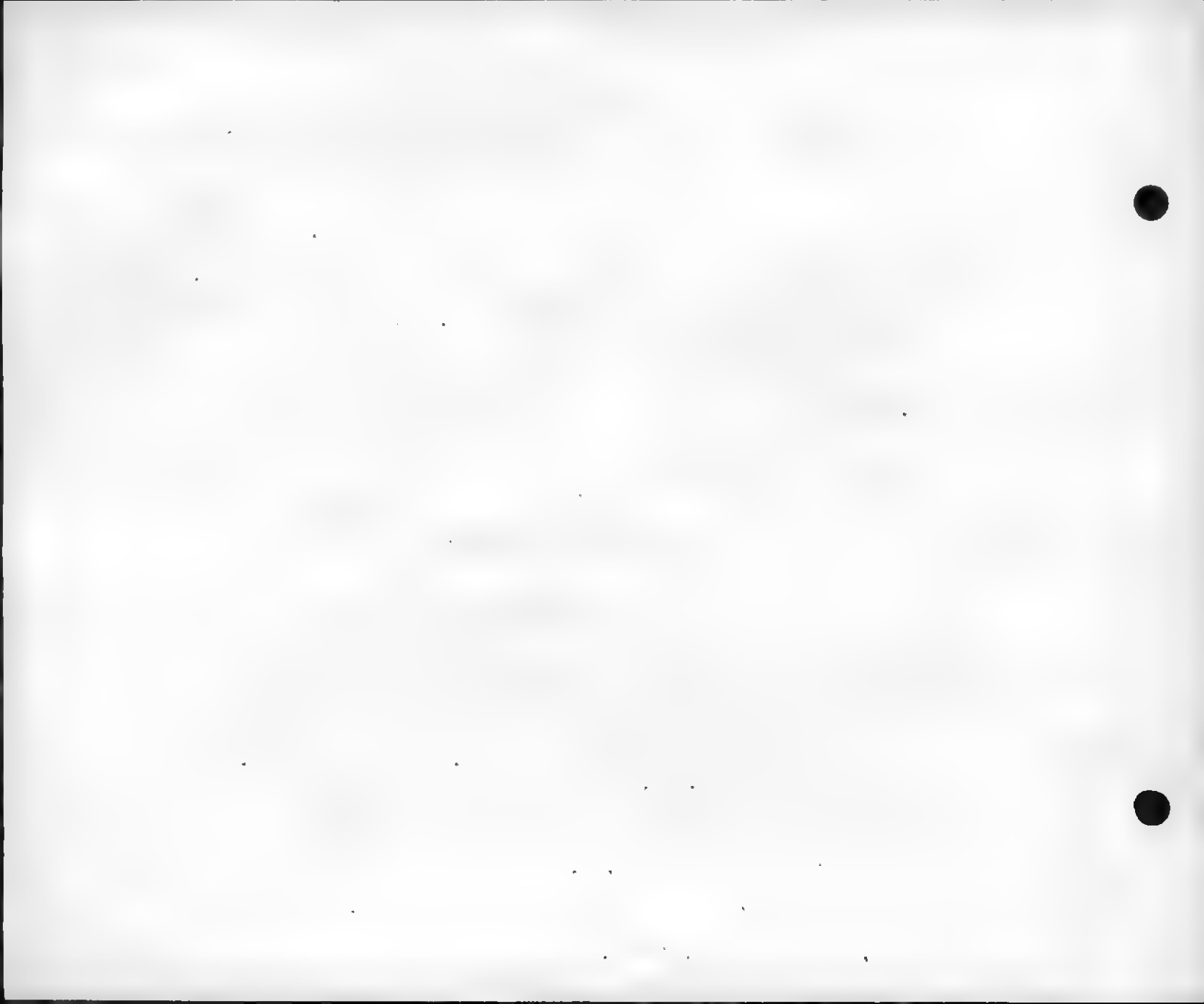
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) College Park d. STREET ADDRESS 4802 Hollywood Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mabel Middle M Last Howell		4. DATE OF DEATH Month 12 Day 21 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 18, 1914 9. AGE (In years last birthday) 53 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Statistician Instructor		10b. KIND OF BUSINESS OR INDUSTRY U of Maryland	
11. BIRTHPLACE (State or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Garner		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 578 32 8506	
17. INFORMANT Chester A. Howell		Address Same as #2 (husband)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH minutes unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D. EXAMINER'S NAME (Type)		22. DATE SIGNED 12-21-67 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/23/67	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln	23d. LOCATION (City, town or county) (State) Colmar Manor P.G. Md.
24. FUNERAL DIRECTOR Francis Gasch's Sons ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE DEC 28 1967 25b. REGISTRAR'S SIGNATURE	

Male



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1751

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 22 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chapel Oaks d. STREET ADDRESS 5702 Oak Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last George Humphrey				4. DATE OF DEATH Month Day Year Dec. 19, 1967			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1903	9. AGE (In years lost birthday) 64 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) St. Paul, N.D.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Wm. Humphrey				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Daisy Riser Address 3312 - Human Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia 35 yr DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) due to Pyelonephritis DUE TO (c) severe liver arterio sclerosis & M. Humphrey - years						INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) chronic decubitus ulcers - arterio sclerosis - heart disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			
20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (X) (this hospital) attended the deceased from Nov. 27, 1967 , to Dec. 19, 1967 , that (X) (we) lost the deceased alive on Dec. 19, 1967 , and that death occurred at 10:15 AM , from causes and on the date stated above							
22a. SIGNATURE Till Bergemann M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. AM. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 12/22/67	
22c. PHYSICIAN'S NAME (Type) Till Bergemann, M.D.				22d. ADDRESS Prince Georges General Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Jan 3, 1968		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial		23d. LOCATION (City or town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR John W. Latney				25a. REC'D BY REGISTRAR 3831 - Ga. Ave. Md.		25b. REGISTRAR'S SIGNATURE John W. Latney	



FOR STATE
HEALTH DEPT.

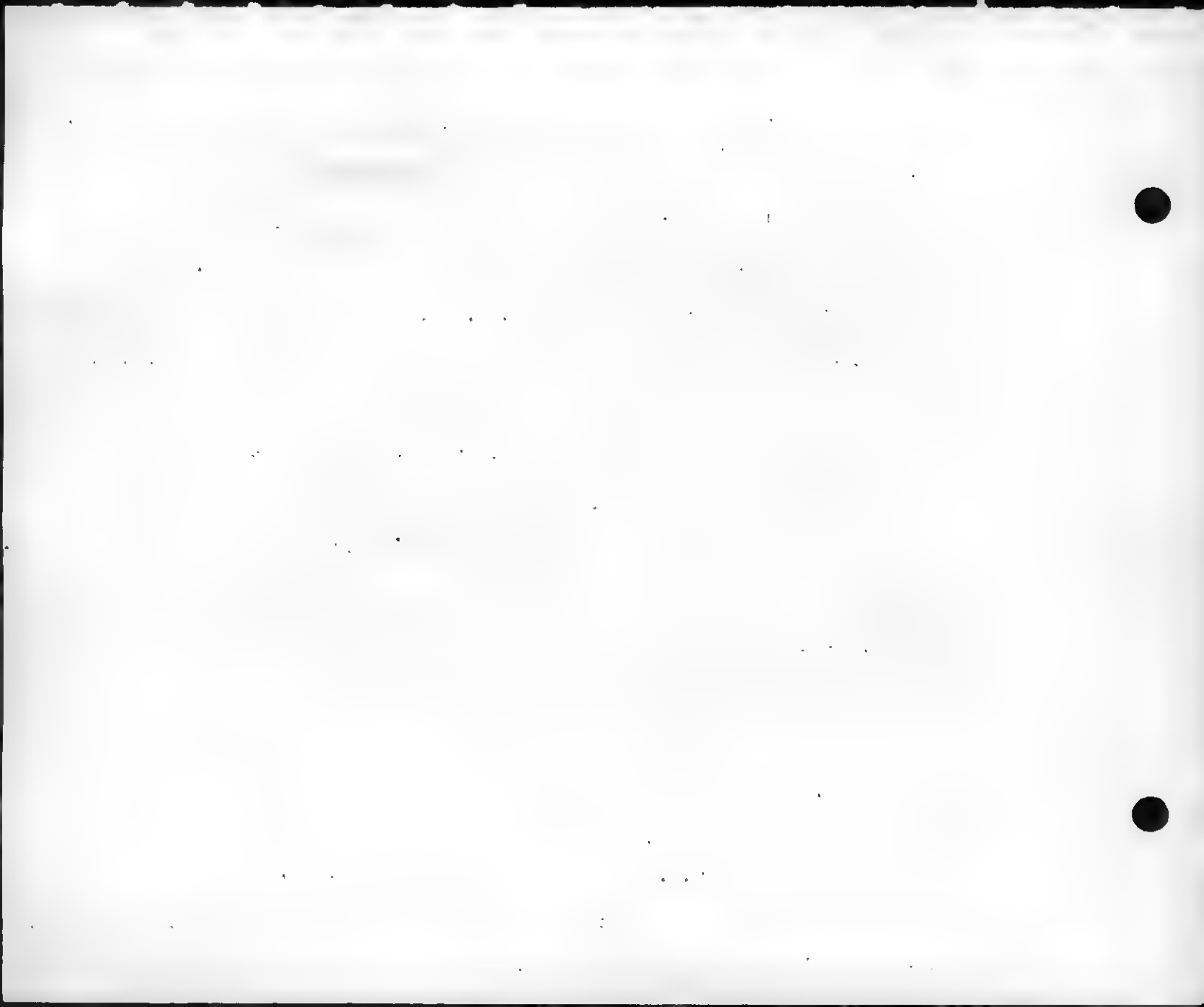
TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISM (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11515

1. PLACE OF DEATH a. COUNTY Prince George's		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN ID DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant	
3. NAME OF DECEASED (Type or print) First Middle Last George Bernard Hunt		4. DATE OF DEATH Month Day Year Dec. 23 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 17, 1887
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Theater		9b. KIND OF BUSINESS OR INDUSTRY Self	9c. AGE (In years last birthday) 80
10a. CITIZENSHIP (Give kind of work done during most of working life, even if retired) Retired Theater		10b. KIND OF BUSINESS OR INDUSTRY Self	10c. AGE (In years last birthday) 80
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Hunt		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1916 579 12 8176A	
17. INFORMANT Virginia L. Hunt		Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Arteriosclerotic heart disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH minutes over 2 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus over 5 years			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 12-26-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address (City, town or county) Baltimore, Prince Georges county	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/28/67	23c. NAME OF CEMETERY OR CREMATORY Baltimore National	23d. LOCATION (City, town or county) (State) Baltimore Baltimore Md.
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR JAN 2 1968	
		25b. REGISTRAR'S SIGNATURE	



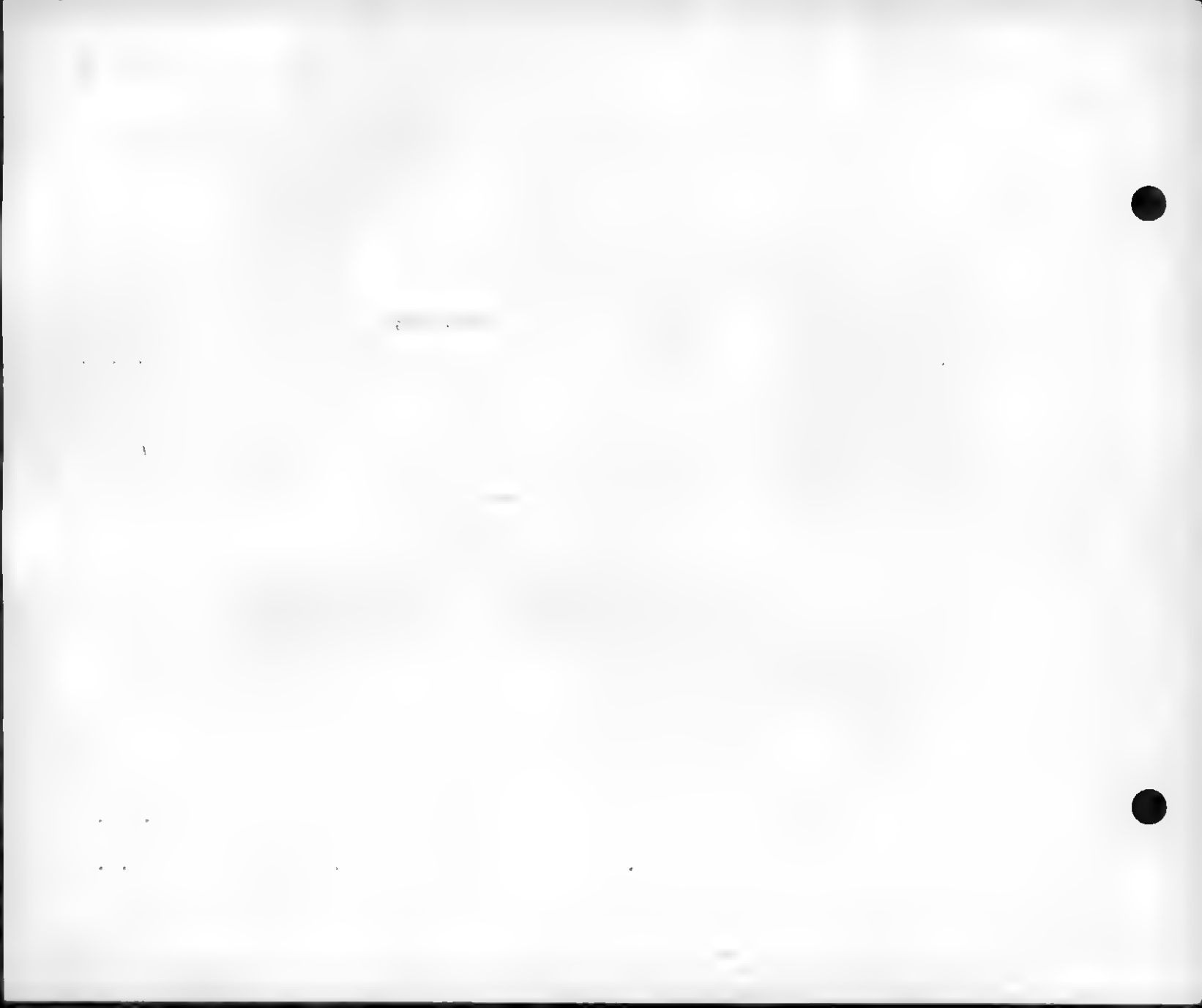
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17516

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 8 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale d. STREET ADDRESS 6201 Roanoke Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3 NAME OF DECEASED (Type or print) First Middle Last William John Hutchings				4. DATE OF DEATH Month Day Year Dec 10 1967											
5 SEX Male		6. COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 22, 1894		9 AGE (In years lost birthday) 73 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Surveyor		11. BIRTHPLACE (City & State, or foreign country) Pennsylvania		12 CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME William Hutchings				14 MOTHER'S MAIDEN NAME Ann Yarrow											
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I				16 SOCIAL SECURITY NO. 170 09 6019		17 INFORMANT Address Nelda H. Leathers Same as #2 (daughter)									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Thromboembolism 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the rectum DUE TO (c) Bile Peritonitis												INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)											
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)							
21 I certify that (I) (this hospital) attended the deceased from 12-02 , 19 67 , to 12-10 , 19 67 , that (I) (we) last saw the deceased alive on 12-10 , 19 67 and that death occurred at 3:25 PM , from causes and on the date stated above.															
22a SIGNATURE <i>John H. Bayly</i> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>												22b. DATE SIGNED Dec. 11, 1967			
22c. PHYSICIAN'S NAME (Type) John H. Bayly, M.D.												22d ADDRESS 1835 Eye St., NW, Washington, D.C.			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial				23b DATE THEREOF 12/14/67		23c NAME OF CEMETERY OR CREMATORY Memorial Shrine				23d LOCATION (City or Town) (County) (State) Carveton Luzerne Co Pa					
24 FUNERAL DIRECTOR ADDRESS Francis Gasch's Sons Hyattsville, Md.						25a REC'D BY REGISTRAR DEC 18 1967		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17517

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesley		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 7240 Joplin Street	
3. NAME OF DECEASED (Type or print) First Myra Middle E. Last Jennings		4. DATE OF DEATH Month Dec. Day 10 Year 1967	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-10-25
9. AGE (In years lost birthday) 42 yrs		10. IF UNDER 1 YEAR Months 17 Days 17 Hours 17 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME Clara Reese	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Bernice Taylor		Address 7240 Joplin St	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Septic shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Infection DUE TO (c) advanced carcinoma of cervix			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that xx (this hospital) attended the deceased from 12-4 , 19 67 at 12-10 , 1967, that xx (we) last saw the deceased alive on 12-10 , 19 67 , and that death occurred at 5:15 PM , from causes and on the date stated above.			
22a. SIGNATURE C. T. Fates		22b. DATE SIGNED 12/10/67	
22c. PHYSICIAN'S NAME (Type) C. T. Fates, M. D.		22d. ADDRESS Prince Georges General Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/14/67	23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park	23d. LOCATION (City or Town) (County) (State) Maryland
24. FUNERAL DIRECTOR Stewart General Home		25a. REC'D BY REGISTRAR DEC 14 1967	25b. REGISTRAR'S SIGNATURE Charles Jones



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17518

1 PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly md</u>			c. LENGTH OF STAY IN 1b <u>1 mo 17 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland md</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pr. Geo. Gen'l Hosp.</u>				d. STREET ADDRESS <u>2227 Houston ST</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Francis Roy Jewell</u>				4. DATE OF DEATH Month <u>12</u> Day <u>22</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7-3-1907</u>		9 AGE (In years last birthday) <u>60</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wash, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W. Jewell</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Delihay</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u> </u>		17. INFORMANT <u>Hospital Record</u> Address <u> </u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SHOCK, Hypovolemic</u> DUE TO <u>PNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u> </u> DUE TO <u>Post-Enteric-Enterocystitis</u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>11-5-</u> <u>1967</u> , to <u>12-22</u> <u>1967</u> , that (I) (we) last saw the deceased alive on <u>12-22</u> <u>1967</u> , and that death occurred at <u>6 P</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>R. Longoria</u>				22b. DATE SIGNED <u>12-23-1967</u>		22c. PHYSICIAN'S NAME (Type) <u>R. Longoria</u>	
22d. ADDRESS <u>5313 Landover Rd Cheverly, Md</u>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-26-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland Pr Geo Md</u>	
24. FUNERAL DIRECTOR <u>Matthewly 131-11th St. S.E.</u>				25a. REC'D BY REGISTRAR DATE <u>DEC 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)
20M 5-65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, -301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
11519									
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville					c. LENGTH OF STAY IN b. 5-Yrs., 7 Mos.				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Forestville Nursing Home					d. STREET ADDRESS Mitchellville R.D.#2-Box 53				
3. NAME OF DECEASED (Type or print) Alice Jones.					4. DATE OF DEATH Month December Day 4 Year 1967.				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 13, 1876		9. AGE (In years last birthday) 91 yrs.	
						IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk					10b. KIND OF BUSINESS OR INDUSTRY U. S. Treasury Department				
13. FATHER'S NAME John C. Jones					14. MOTHER'S MAIDEN NAME Frances Clark				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 217-42-2070-T				
					17. INFORMANT Mrs. Evelyn Jones Sears-Md. Address Hall, 21073				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility. General debility									
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility. General debility									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. [City or town] (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Feb. 12/4 1967 to Dec. 4 1967 that (I) (we) last saw the deceased alive on 12/4 1967 and that death occurred at 5:20 P.M. from the causes and on the date stated above.									
22a. SIGNATURE A. Clark Holmes, M.D.					22b. DATE SIGNED 12/4/67				
22c. PHYSICIAN'S NAME (Type) A. Clark Holmes, M.D.					22d. ADDRESS Upper Marlboro, Md. 20870:				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/7/67		23c. NAME OF CEMETERY OR CREMATORY St. Barnabas Cemetery		23d. LOCATION (City, town or county) Leeland		23e. (State) Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Fun'l Home-Upper Marlboro,					25a. REC'D BY REGISTRAR DEC 8 1967				
					25b. REGISTRAR'S SIGNATURE J. Charles Judge				

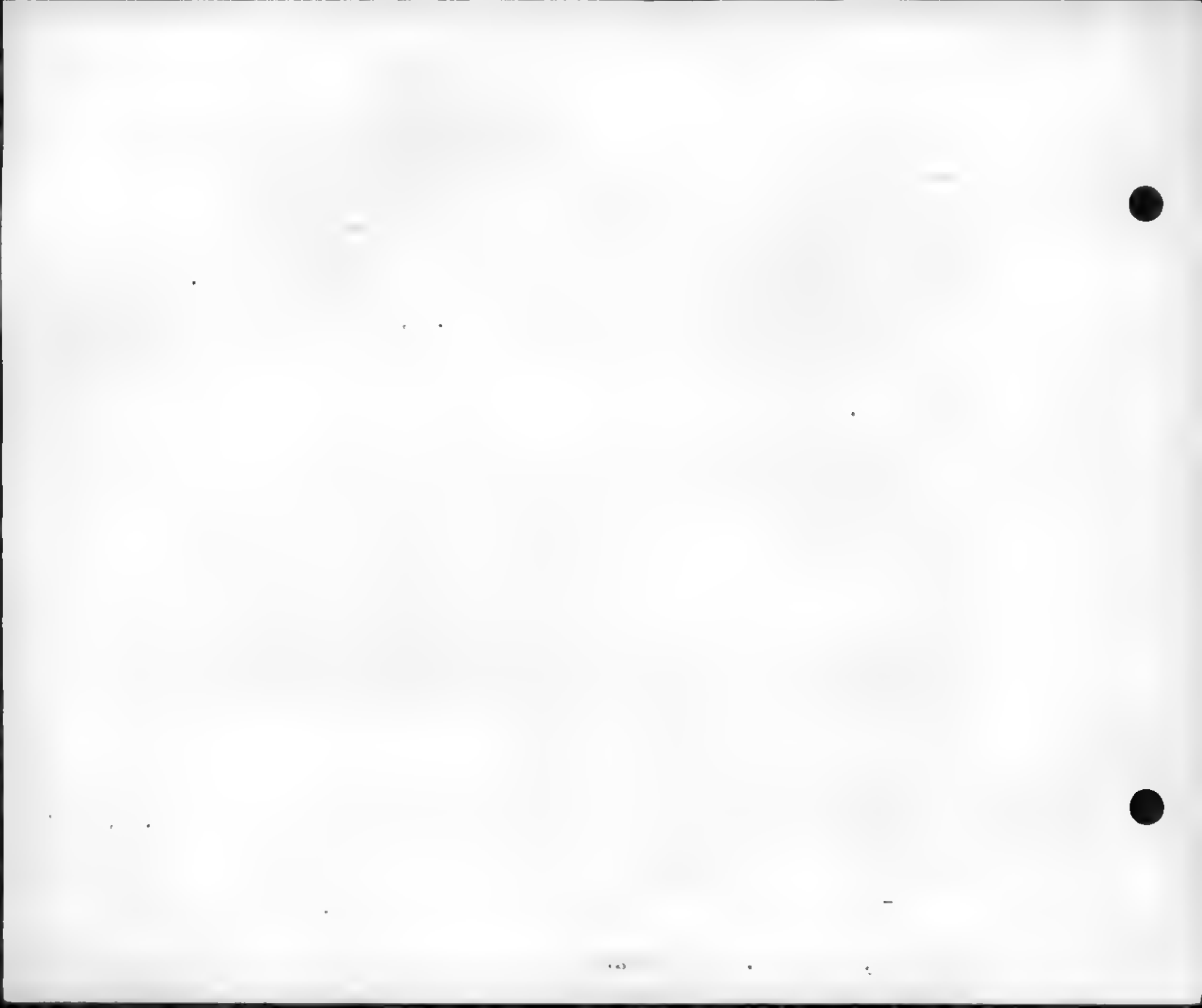
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11520

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 26 hours			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 8825 Dangerfield Road		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy Jones				4. DATE OF DEATH Month Day Year Dec 5 19 67			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 4, 1967	
9. AGE (In years last birthday) 1		10. IF UNDER 1 YEAR Months Days 1		11. IF UNDER 24 HRS. Hours Min 1		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)	
13. FATHER'S NAME Charles L. Jones				14. MOTHER'S MAIDEN NAME Carol Ann Barton			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY EDEMA 774X DUE TO (b) CARDIOVASCULAR INSUFFICIENCY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) PREDATORITY							INTERVAL BETWEEN ONSET AND DEATH
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the doctor) attended the deceased from 12/4/67 to 12/5/67 ; that (I) (we) lost the deceased on 12/5/67 , and that death occurred at 3:00 PM , from causes and on the date stated above.							
22a. SIGNATURE <i>[Signature]</i> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED Dec. 6, 1967	
22c. PHYSICIAN'S NAME (Type) DR. ALNO TALENA				22d. ADDRESS 4400 S. ...			
23a. BURIAL, CREMATION, REMOVAL (Specify) <input checked="" type="checkbox"/>		23b. DATE THEREOF 12-9-67		23c. NAME OF CEMETERY OR CREMATORY Prince George's General Hosp.		23d. LOCATION (City or town) (County) (State) Cheverly, Maryland	
24. FUNERAL DIRECTOR <i>[Signature]</i> Harry W. Penn, Jr. Administrator				25a. REC'D BY REGISTRAR DEC 18 1967		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

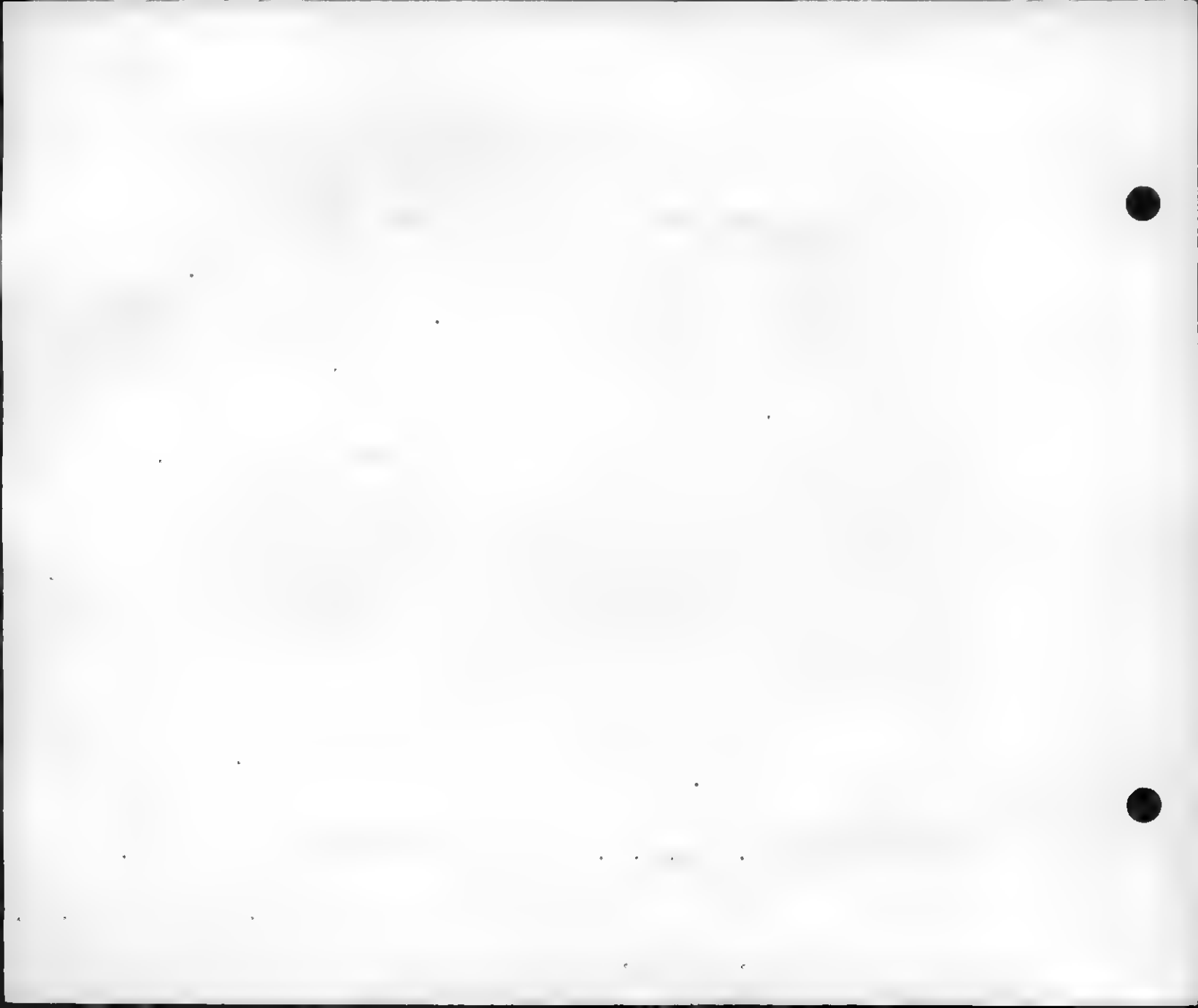
VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17521

1 PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 1228 57th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Haidee Middle W. Last Jones		4 DATE OF DEATH Month Dec. Day 7, Year 19 67			
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sept. 1, 1910		9 AGE (In years last birthday) 57 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Washington D. C.	
13. FATHER'S NAME M Quillan W. Grist		14. MOTHER'S MAIDEN NAME Haidee Trent			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16 SOCIAL SECURITY NO		17. INFORMANT Address Elizabeth Bennett 1228 57th Ave. Capitol Hgts	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration and Liver Failure DUE TO (b) Metastatic Epidermoid Carcinoma DUE TO (c) Carcinoma of Vallecula (Tongue) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 18 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)					9 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Nov. 19, 1967 , to Dec. 7, 1967 , that (I) (we) last saw the deceased alive on Dec. 7, 1967 , and that death occurred at 6:50 PM , from causes on and on the date stated above.					
22a. SIGNATURE Edwin R. Lamm		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/19/67	
22c. PHYSICIAN'S NAME (Type) Edwin R. Lamm, M. D.		22d. ADDRESS 3231 Superior Lane, Bowie, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/11/67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Prince Georges, Md.	
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road, Suitland, Maryland		25a. REC'D BY REGISTRAR DEC 14 1967		25b. REGISTRAR'S SIGNATURE James Judge	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17522

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE North Dakota b. COUNTY Wells		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b Doa		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital			e. STREET ADDRESS Rural Route		
3 NAME OF DECEASED (Type or print) First Edna Middle T. Last Kahl			4. DATE OF DEATH Month 12 Day 2 Year 1967		
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8-2-1892		9 AGE (In years last birthday) 75 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of work on life, even if retired) Ret. Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11 BIRTHPLACE (State or foreign country) Iowa	
13 FATHER'S NAME Samuel E. Loudenslager			14 MOTHER'S MAIDEN NAME Ida Miller		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no (If yes give war or dates of service)		16 SOCIAL SECURITY NO 501 36 3192		17 INFORMANT Delores K. Everts 2833 Sudberry Lane Bowie, Maryland	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Hypertensive arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH minutes over 5 yrs.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 12-2-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 12/3/67	23c. NAME OF CEMETERY OR CREMATORY Neuenschwander F. Home		23d. LOCATION (City or Town) (County) (State) Fessenden Wells N. D.	
24 FUNERAL DIRECTOR Francis Gasch's Sons		ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DEC 5 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

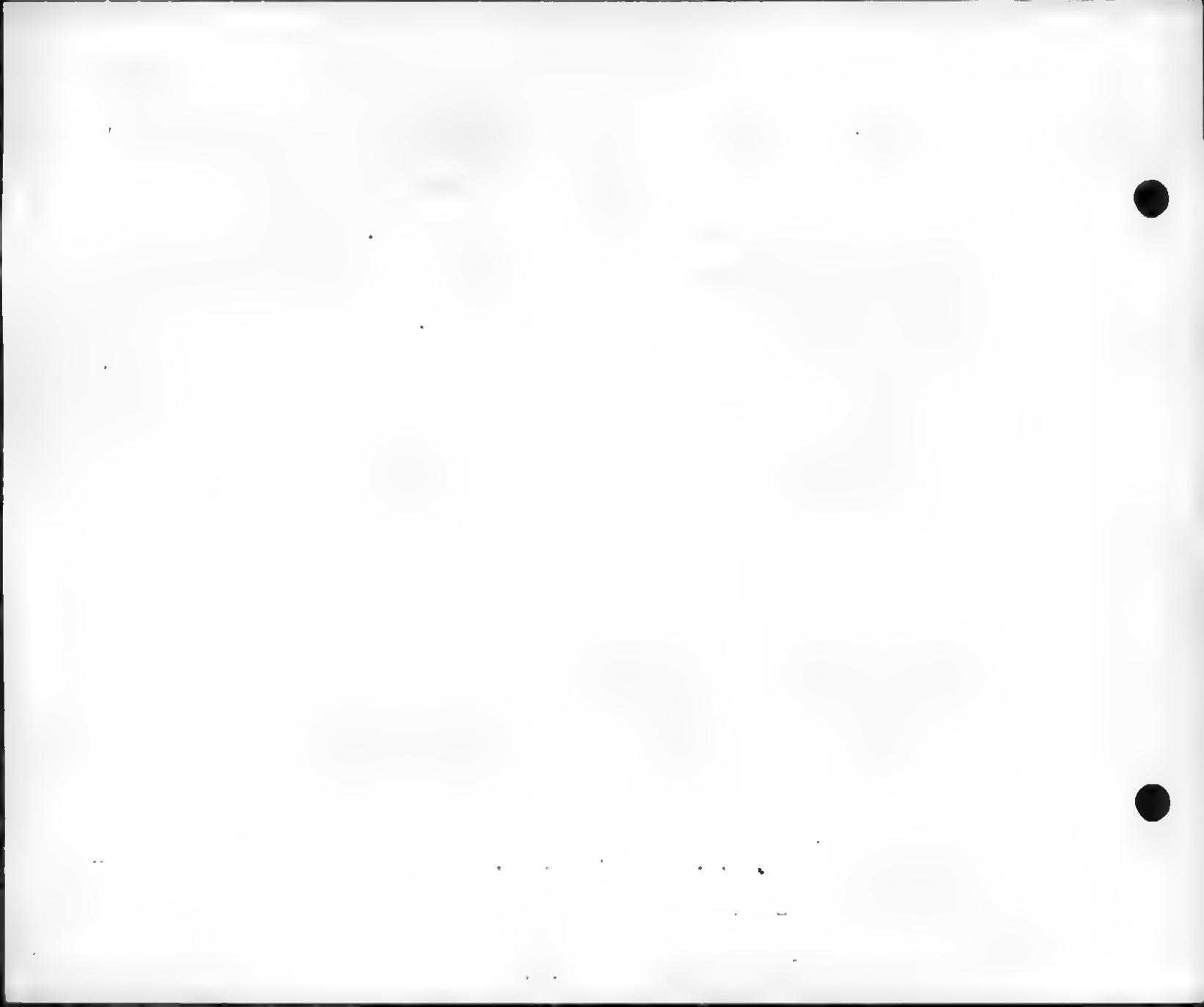
Items 18, 20, 21 filed 1967 MARYLAND STATE DEPARTMENT OF HEALTH
2-16-68 mt DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17518

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17523

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b DOA			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillside 1C-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 1407 50th. Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Roberta Middle A Last Kantro				4. DATE OF DEATH Month 12 Day 11 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 Feb. 1914		9. AGE (In years last birthday) 53 yrs	IF UNDER 1 YEAR Months 12 Days 11	IF UNDER 24 HRS Hours 19 Min. 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis Nible				14. MOTHER'S MAIDEN NAME Nellie Cox			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Nancy Evans Address 684 20th Ave San Francisco, Calif			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Combined intoxication 1708 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Barbituates & Doriden DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18) Took overdose of Medication					
20c. TIME OF INJURY Month Day, Year Hour am Xpm 12-11 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) Home		20f. (City or town) Hillside (County) P. G. (State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				22. DATE SIGNED 12-13-67			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 12-15-1967		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City or Town) Suitland, Md (County) (State)	
23e. FUNERAL DIRECTOR Robert A Mattingly		131 ADDRESS 11th St S.E. Wash. D.C.		25a. REC'D BY REGISTRAR DEC 15 1967		25b. REGISTRAR'S SIGNATURE John A. Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

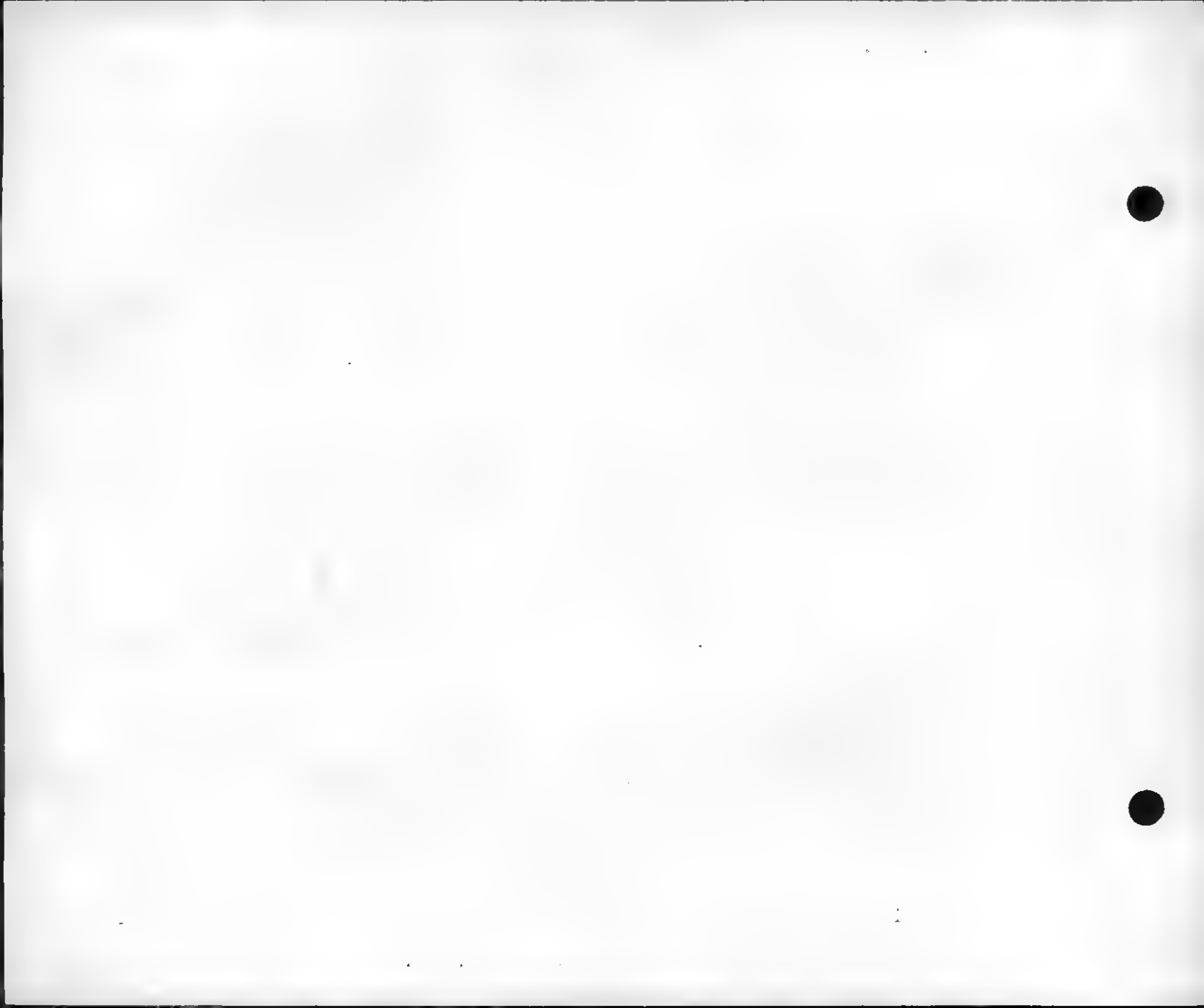
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17524

1 PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton Md.</u>		c. LENGTH OF STAY IN 1b <u>10 hours</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Clinton Community Hospital</u>		d. STREET ADDRESS <u>7620 Bedford Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Rebecca Kemper</u>		4. DATE OF DEATH <u>12 23 19 67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/17/32</u>
9. AGE (In years lost birthday) <u>35 yrs.</u>		10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>H.D. Dinger Grand-son-in-law</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO <u>Acute Pulmonary Edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>ACUTE CONGESTIVE HEART FAILURE</u> DUE TO <u>ARTERIOSCLEROTIC DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 HRS</u> <u>10 HRS</u> <u>10 1/2 HRS</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ACUTE VIRAL RESPIRATORY SYNDROME WITH BRONCHOLITIS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year <u>None</u>		20d. INJURY OCCURRED <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>None</u>		20f. (City or town) (County) (State) <u>None</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 22 1967</u> to <u>Present</u> that (I) (we) last saw the deceased alive on <u>Dec 22 1967</u> and that death occurred at <u>4:57</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Arthur Shaver Jr. M.D.</u>		22b. DATE SIGNED <u>12/23/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ARTHUR SHAVER JR.</u>		22d. ADDRESS <u>8808 BRANCH AVE. - CLINTON MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-26-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Orleans Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Orleans Virginia</u>	
24. FUNERAL DIRECTOR <u>Charles E. Gange</u>		25a. REC'D BY REGISTRAR <u>DEC 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

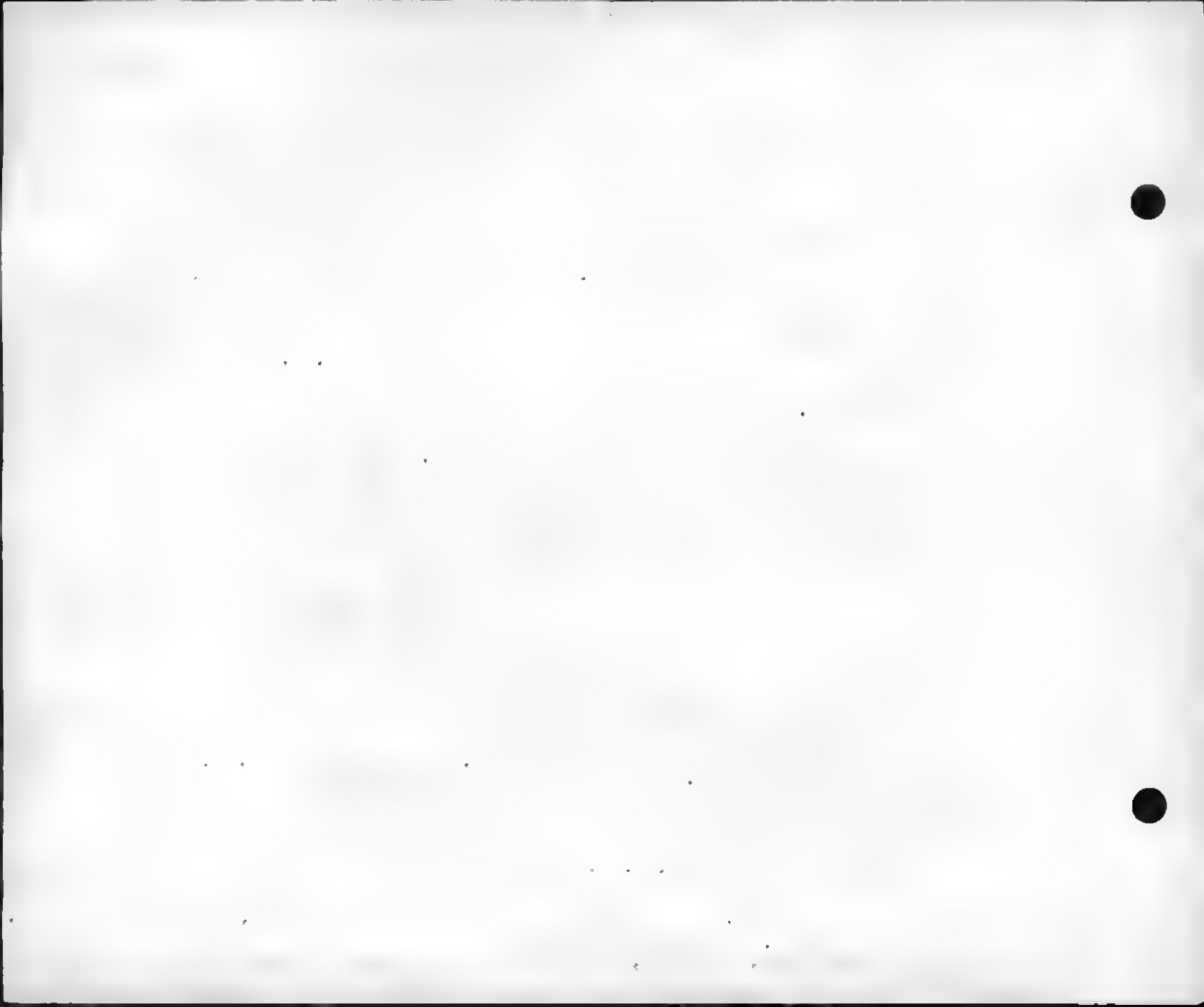
VR A15 (4)
25M 1/67

1
520
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #8 Film #G396 12/22/59 ph

CERTIFICATE OF DEATH

17525

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 10 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville d. STREET ADDRESS 11128 Baltimore Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Evelyn E. King		4. DATE OF DEATH Month Dec. Day 5 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/9/1916/1915
9. AGE (In years lost birthday) 52 yrs		10. IF UNDER 1 YEAR Months 5 Days 19 Hours 67 Min	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. KIND OF BUSINESS OR INDUSTRY Washington D. C.	
13. FATHER'S NAME Owen Gray Sr.		14. MOTHER'S MAIDEN NAME Violet Blandford	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO Same as #2	
17. INFORMANT Walter C. King		Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Nutritional Cirrhosis of the liver, severe DUE TO Hepatic coma, clinical Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) Severe Jaundice, clinical (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (he) (this hospital) attended the deceased from Nov. 25, 1967 , to Dec. 5, 1967 , that he (we) last saw the deceased alive on Dec. 5, 1967 , and that death occurred at 5:55PM , from causes and on the date stated above			
22a. SIGNATURE Till Bergemann, M. D.		22b. DATE SIGNED DEC 11 1967	
22c. PHYSICIAN'S NAME (Type) Till Bergemann, M. D.		22d. ADDRESS Prince Georges General Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/9/67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland, Prince Georges, Md.
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road, Suitland, Maryland		25a. REC'D BY REGISTRAR DEC 11 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

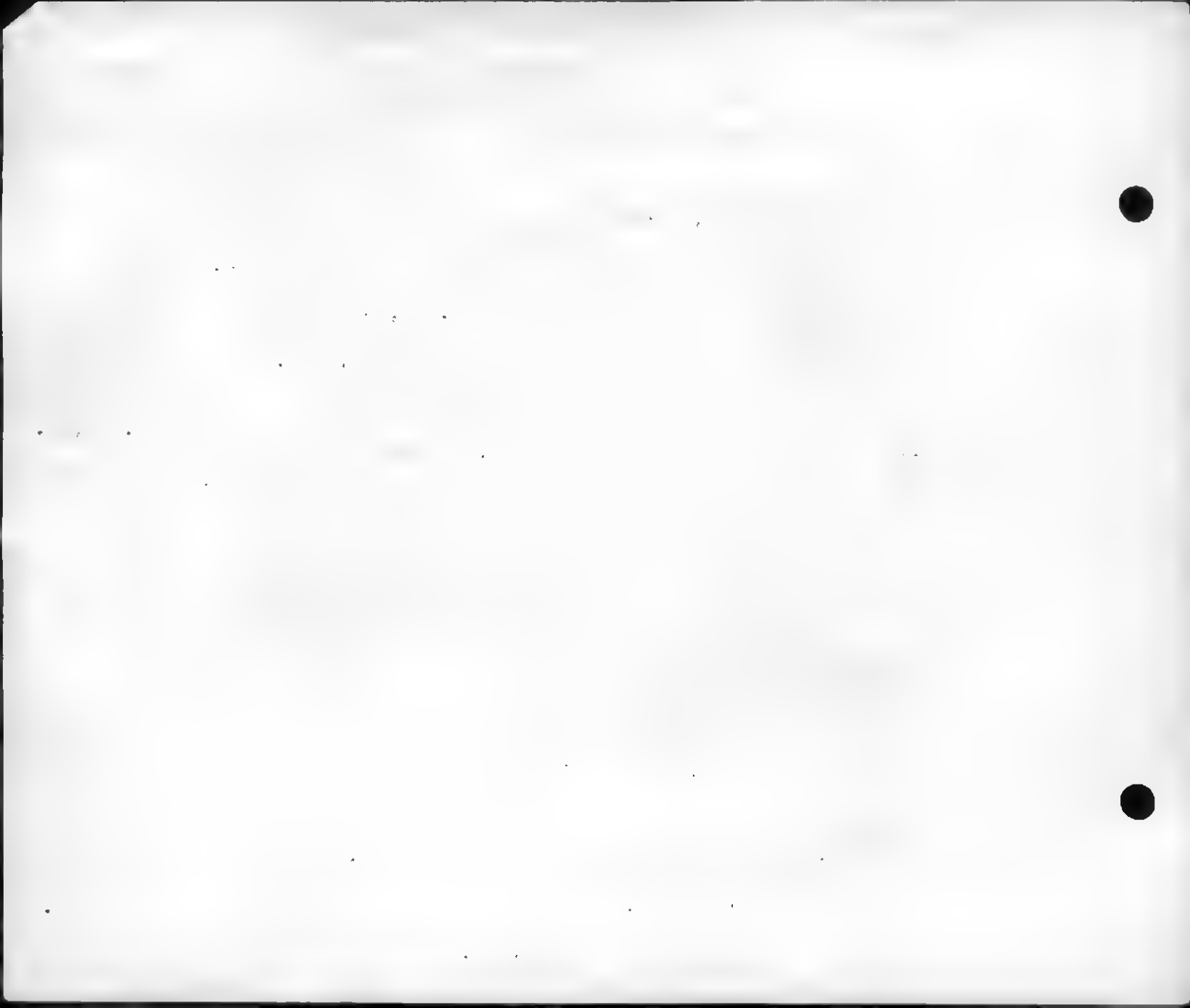
VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17526

1 PLACE OF DEATH a. COUNTY Prince George, s MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b North Beach	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George, s Gen, l Hospital		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First MINNIE Middle VIRGINIA Last Kirin		4. DATE OF DEATH Month Dec. Day 15 Year 67	
5 SEX Female	6. COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sept. 29, 1904
9. AGE (In years last birthday) 63 yrs		IF UNDER 1 YEAR Months 15 Days 6	IF UNDER 24 HRS Hours 15 Min 6
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Madison Co., Va.
13. FATHER'S NAME David Alger		14. MOTHER'S MAIDEN NAME Lilly Weakley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) -----		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs. Martha Aiken 819 Union Ave.		Address Balto., 11, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arterio sclerosis generaliz'd DUE TO (c) Hypertension severe			INTERVAL BETWEEN ONSET AND DEATH 10 minutes Several months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension severe			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 19 1967 , 19 12/6 , 1967, that (I) (we) last saw the deceased alive on 12/6 , 1967, and that death occurred at 5:00 P.M. from causes and on the date stated above			
22a. SIGNATURE L. Linz		22b. DATE SIGNED Dec. 6, 1967	
22c. PHYSICIAN'S NAME (Type) L. Linz		22d. ADDRESS Cheverly, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 9, 1967	23c. NAME OF CEMETERY OR CREMATORY So. Memorial Gardens	23d. LOCATION (City or Town) (County) (State) Dunkirk Calvert Md.
24. FUNERAL DIRECTOR Hutchins Funeral Home		25a. REC'D BY REGISTRAR DEC 12 1967	
ADDRESS Owings, Md.		25b. REGISTRAR'S SIGNATURE James J. Jones	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 2 File G396 1/2/68 kk

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17528

1 PLACE OF DEATH a COUNTY Prince George MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE PA. Pennsylvania b COUNTY Lancaster	
b CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Camp Springs		c LENGTH OF STAY IN 1b 30 min.	
d NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Andrews Air Force Base Hospital		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Thomas Middle Earl Last Knickerbocker		4 DATE OF DEATH Month 12 Day 18 Year 1967	
5 SEX M	6 COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9 Mar., 1948
9a AGE (In years last birthday) yrs 19		9b AGE (In years last birthday) yrs 19	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b KIND OF BUSINESS OR INDUSTRY U.S. Air Force	
11 BIRTHPLACE (State or foreign country) Penna.		12 CITIZEN OF WHAT COUNTRY? U.S.	
13 FATHER'S NAME EARL KNICKERBOCKER		14 MOTHER'S MAIDEN NAME LUCILLE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes Oct., 66-death		16. SOCIAL SECURITY NO. 188-38-5933	
17 INFORMANT Air Force Records		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive brain damage 7206 DUE TO (b) Compression of head in hanger door. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 45 min.	
20a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH 20		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Head caught in closing hanger doors.	
20c TIME OF INJURY Month, Day, Year Hour o m 6:15 pm 12 18 19 67		20d INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hanger # 1, Andrews AFB, P.G. Md.		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 12-18-67	
ACTUAL SIGNATURE John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) BUR-REM		23b DATE THEREOF 12-23-67	
23c NAME OF CEMETERY OR CREMATORY MELLINGERS CEM.		23d LOCATION (City or Town) (County) (State) LANCASTER PENN.	
24 FUNERAL DIRECTOR FALLS CHURCH Funeral Home, VA.		25b REGISTRAR'S SIGNATURE DEC 26 1967	

X

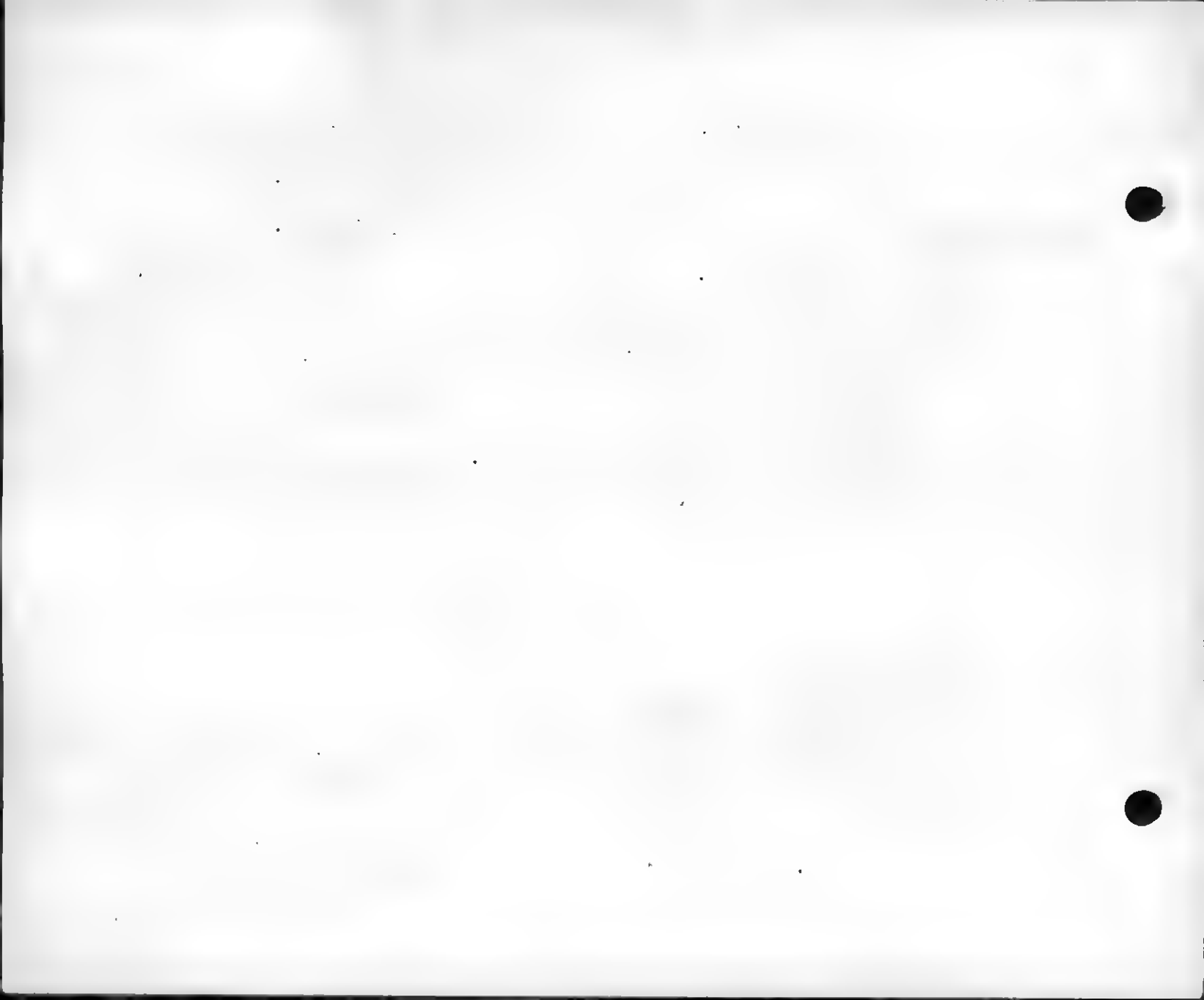
CERTIFICATE OF DEATH

17527

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admision) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Md			c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edmonston, Md.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital				d. STREET ADDRESS 4807 53rd Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert T. Kivett				4. DATE OF DEATH December 26, 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/17/08	
9. AGE (In years lost birthday) 59 yrs.		10a. USUAL OCCUPATION (Give kind of work done including life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Gas Station		11. BIRTHPLACE (County & State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Jessie Calvin Kivett			
14. MOTHER'S MAIDEN NAME Ruby Cable				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			
16. SOCIAL SECURITY NO 213 10 1510				17. INFORMANT Address Mrs. Francis Kivett, same address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. 5810 IMMEDIATE CAUSE (a) Hepatic car cirrhosis DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 8 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 30, 1967 to Dec 26, 1967 , that (I) (we) last saw the deceased alive on Dec 26, 1967 , and that death occurred at 6:00 P.M. from causes on the date stated above							
22a. SIGNATURE Shenard Hayes				22b. DATE SIGNED 12-26-67		22c. PHYSICIAN'S NAME (Type) Dr. Hayes MD	
22d. ADDRESS Hyattsville, Md				22e. MED. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/29/67		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR DATE JAN 2 1968		25b. REGISTRAR'S SIGNATURE Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

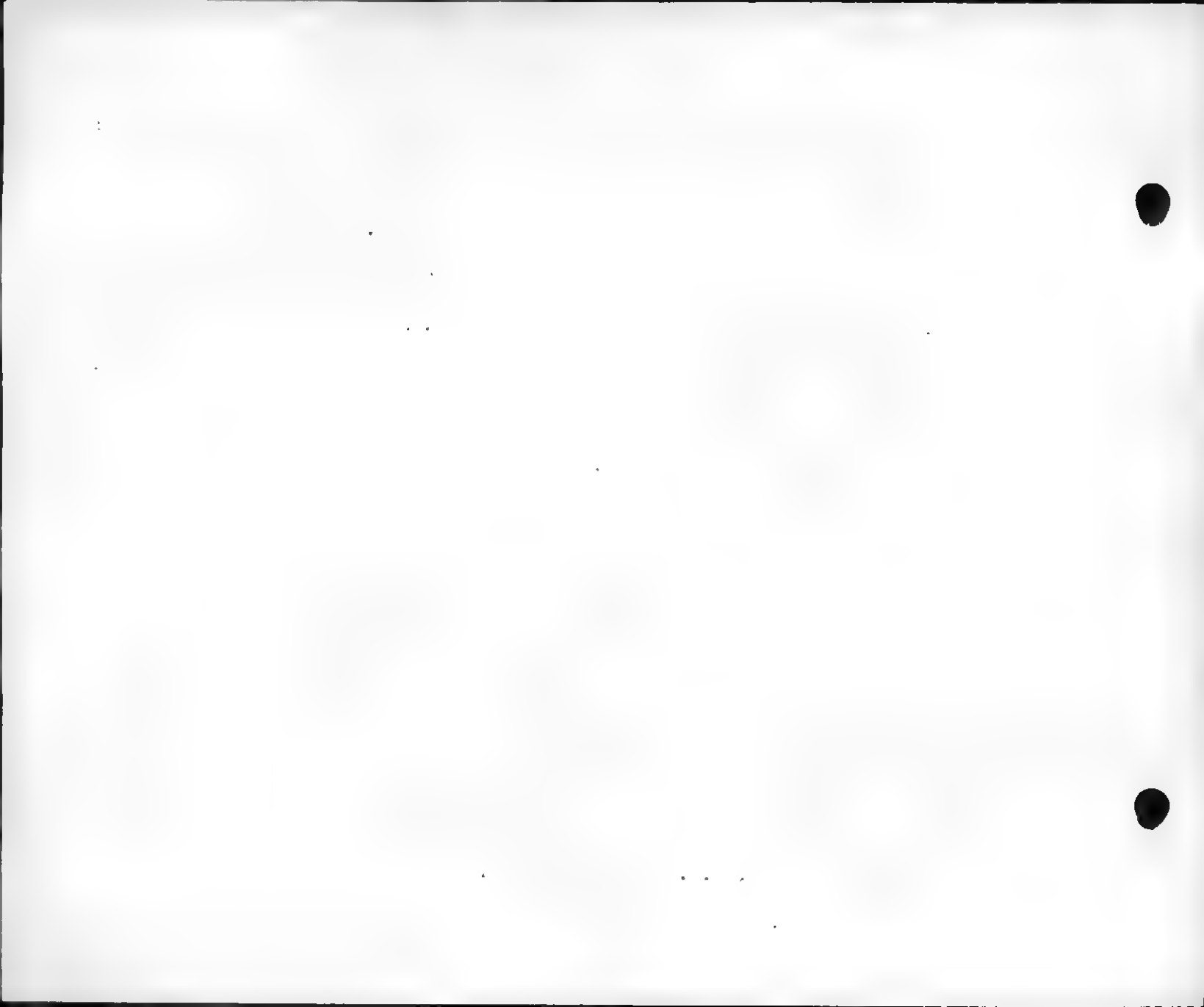
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1529

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN IS DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 811 50th. Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Matthew Mathew Kotula				4. DATE OF DEATH Month 12 Day 15 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 Oct. 1912	9. AGE (In years last birthday) 55 yrs	IF UNDER 1 YEAR Months 12 Days 15	IF UNDER 24 HRS Hours 19 Min 67	
10a. USUAL OCCUPATION (Give kind of work done during most of workable, even if retired) Chef		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Penna		12. CITIZEN OF WHAT COUNTRY? U S A.	
13. FATHER'S NAME Alexander Kotula				14. MOTHER'S MAIDEN NAME Catherine Hosylik			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) yes WWI		16. SOCIAL SECURITY NO 192.05.1607		17. INFORMANT Georgette Kotula. 811.50th ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH minutes unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe, M.D.				22. DATE SIGNED 12-15-67			
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				Address (Street, city, town or county) 811.50th ave			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 12.20.67		23c. NAME OF CEMETERY OR CREMATORY Baltimore. National		23d. LOCATION (City or Town) (County) (State) Baltimore. Maryland	
24. FUNERAL DIRECTOR Lee. Funeral Home. 300.4th st N E				25a. REC'D BY REGISTRAR DEC 21 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u> c. LENGTH OF STAY IN b. <u>197</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BOWIE RD RT 2 BOX 226</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEORGES</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u> d. STREET ADDRESS <u>Bowie Rd, Rt 2 Box 226</u>			
3. NAME OF DECEASED (Type or print) <u>WILLIAM A LAMMERS</u>		8. DATE OF BIRTH <u>SEPT. 1 1904</u>		9. AGE (In years last birthday) <u>63</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GARDNER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>US GOVT.</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>PRINCE GEORGES MD USA</u>				12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
13. FATHER'S NAME <u>ARNOLD LAMMERS</u>				14. MOTHER'S MAIDEN NAME <u>MARY G. OTTEN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MARGARET A. LAMMERS</u> Address <u>SCHULD 2 D.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) <u>Paraplegia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Carcinoma Spine</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>3 yrs</u> <u>5 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>8/13</u> <u>1941</u> <u>to 12/28</u> <u>1967</u> , that (I) (we) last saw the deceased alive on <u>12/28/67</u> , and that death occurred at <u>12/28/67</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>J. M. Warren</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>J. M. WARREN</u>		22d. ADDRESS <u>321 PRINCE GEORGE AVE, LAUREL, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/30/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST MARYS CATHOLIC CEM</u>			
23d. LOCATION (City, town, or county) <u>LAUREL</u>		(State) <u>MD.</u>		23e. REC'D BY REGISTRAR <u>J. Charles J. J.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Charles J. J.</u>		ADDRESS <u>530 WASH BLVD, LAUREL, MD.</u>		25a. DATE <u>JAN 4 1968</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

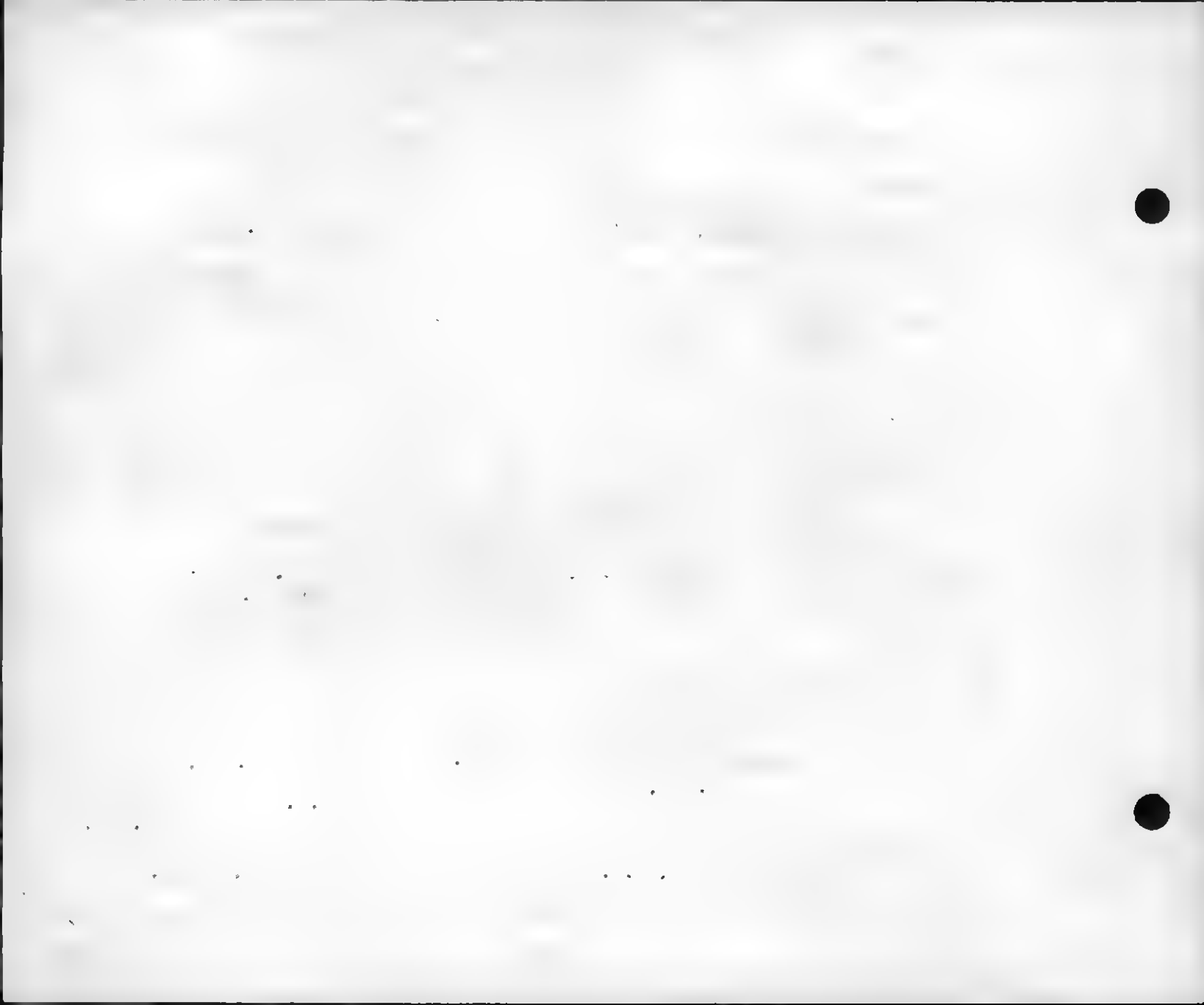
CERTIFICATE OF DEATH

17531

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 3353 Sudlersville S.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Donald N. Lanthrip				4 DATE OF DEATH Month Day Year December 28 1967			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/14/30		9. AGE (In years lost birthday) 37 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) D.C. Gov't.		10b. KIND OF BUSINESS OR INDUSTRY D.C. Gov't.		11 BIRTHPLACE (County & State, or foreign country) TENN.		12 CIT ZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME JAMES W. LANTHRIP				14. MOTHER'S MAIDEN NAME FLORA COHELEY			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.		17 INFORMANT RONALD N. LANTHRIP		Address LAUREL, MD 9353 SUDLERSVILLE S.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Calcific Aortic stenosis, severe; DUE TO Rheumatic Aortic Valvulitis with severe coronary insufficiency; Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Acute myocardial infarction, massive, Inter-ventricle septum and the left ventricle. (c) Acute myocardial infarction, massive, Inter-ventricle septum and the left ventricle.						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I. of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work or work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) the physician attended the deceased from Dec. 28, 1967 to Dec. 28, 1967 , that (I) was last saw the deceased alive on Dec. 28, 1967 , and that death occurred at 3:40 P.M. from causes and on the date stated above.							
22a SIGNATURE <i>Fidel Quintana</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED Dec. 29, 1967			
22c. PHYSICIAN'S NAME (Type) Fidel Quintana, M.D.		22d. ADDRESS 12004 Maycheck Lane, Bowie, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Jan 2, 1968		23c. NAME OF CEMETERY OR CREMATORY GEO. WASHINGTON CEMETARY		23d. LOCAT ON (City or Town) (County) (State) RR 600 Co. Md.	
24 FUNERAL DIRECTOR <i>Charles Judge</i>		ADDRESS 550 WASH BLVD		25a REC'D BY REGISTRAR MAN 4 1968		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 7148 Presley Road			
3. NAME OF DECEASED (Type or print) First Anthony Middle C. Last Leone				4. DATE OF DEATH Month December Day 30, Year 19 67			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/22/16	
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) Rhode Island		12. CITIZEN OF WHAT COUNTRY? U S A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector				10b. KIND OF BUSINESS OR INDUSTRY Aircraft Government			
13. FATHER'S NAME Lorenzo Leone				14. MOTHER'S MAIDEN NAME Concetta			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W W 11		16. SOCIAL SECURITY NO. 038 10 1371		17. INFORMANT Carmela C. Leone Address Lanham, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Tamponade 451X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rupture of Aortic Aneurism of Ascending Aorta DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/29, 1967, to 12/30, 1967, that (I) (we) last saw the deceased alive on 12/29/1967, and that death occurred at 8:15 AM, from the causes and on the date stated above.							
22a. SIGNATURE Iradj Sadeghian M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/30/67	
22c. PHYSICIAN'S NAME (Type) Iradj Sadeghian				22d. ADDRESS 6813 Riverdale Rd., Riverdale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan 2, 1968		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town or county) (State) Washington D. C.	
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR JAN 8 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1-532

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write BURIAL and give nearest town) Riverdale c. LENGTH OF STAY IN b 16 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits write BURIAL and give nearest town) Landover d. STREET ADDRESS 7422 Landover Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Dolly First Middle Last L Lewis		4. DATE OF DEATH 12/10/67 Month Day Year 19	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/31/91 1896
9. AGE (in years last birthday) 71		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Housewife)		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Wm. F. Leonard (Deceased)		14. MOTHER'S MAIDEN NAME Catherine D. Bowers (Deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 579-09-2106	
17. INFORMANT Admitting Record		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY OCCLUSION 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) LITTLE STROKES		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11-24 , 19 67 , to 12-10 , 19 67 , that (I) (we) last saw the deceased alive on 12-9 , 19 67 , and that death occurred at 7 A.M. from causes and on the date stated above.			
22a. SIGNATURE C. J. Houmann		22b. DATE SIGNED 12-10-67	
22c. PHYSICIAN'S NAME (Type) C. J. HOUMANN		22d. ADDRESS RIVERDALE MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/13/67	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.	23d. LOCATION (City or town) (County) (State) Colmar Manor, Md.
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25a. REC'D BY REGISTRAR DEC 18 1967	
Address Mt. Rainier Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

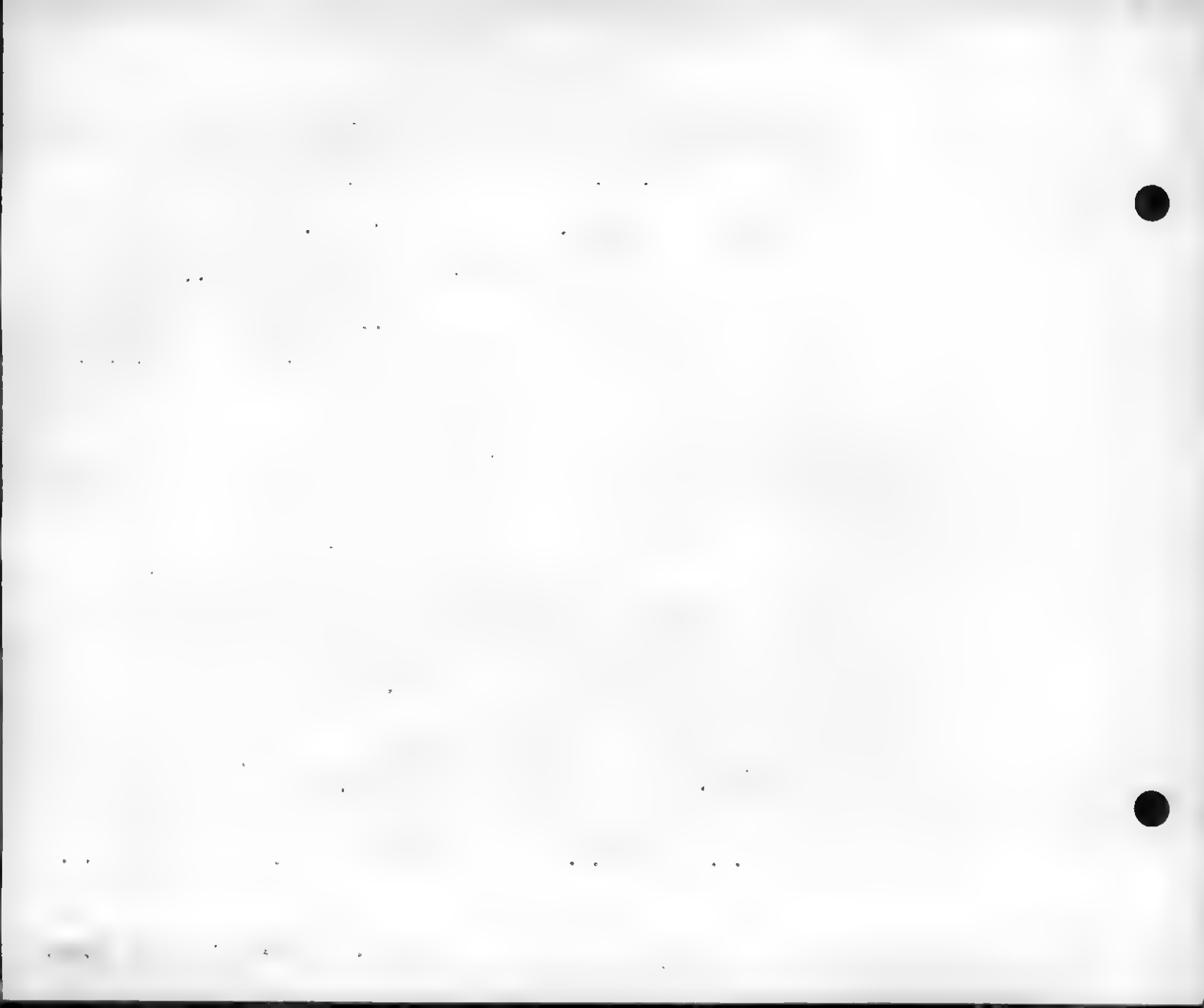
1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17533

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 28 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. STREET ADDRESS 2211 Univ. Blvd	
3. NAME OF DECEASED (Type or print) Lula		4. DATE OF DEATH Month Dec. Day 27 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 25 Feb., 1888 79 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working months, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Somerset, Penn.		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME George Brown		14. MOTHER'S MAIDEN NAME Elizabeth Firl	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. #2	
17. INFORMANT Mr. George Tipton		Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 years (c)		INTERVAL BETWEEN ONSET AND DEATH 1 month	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from Nov 30, 1967 to Dec. 27, 1967 , that (1) (we) last saw the deceased alive on Dec. 27, 1967 , and that death occurred at 11:58 PM from causes and on the date stated above.			
22a. SIGNATURE Samuel J. Sugar M.D.		22b. DATE SIGNED Dec. 27, 1967	
22c. PHYSICIAN'S NAME (Type) Samuel J.N. Sugar, M.D.		22d. ADDRESS 4637 Eastern Ave., Washington, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/1/68	23c. NAME OF CEMETERY OR CREMATORY Summit Mills	23d. LOCATION (City or Town) (County) (State) Somerset County Pa.
24. FUNERAL DIRECTOR Francis Gasch's Sons		25a. REC'D BY REGISTRAR Jan 3 1968	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE John J. Judge	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

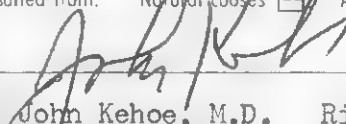

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

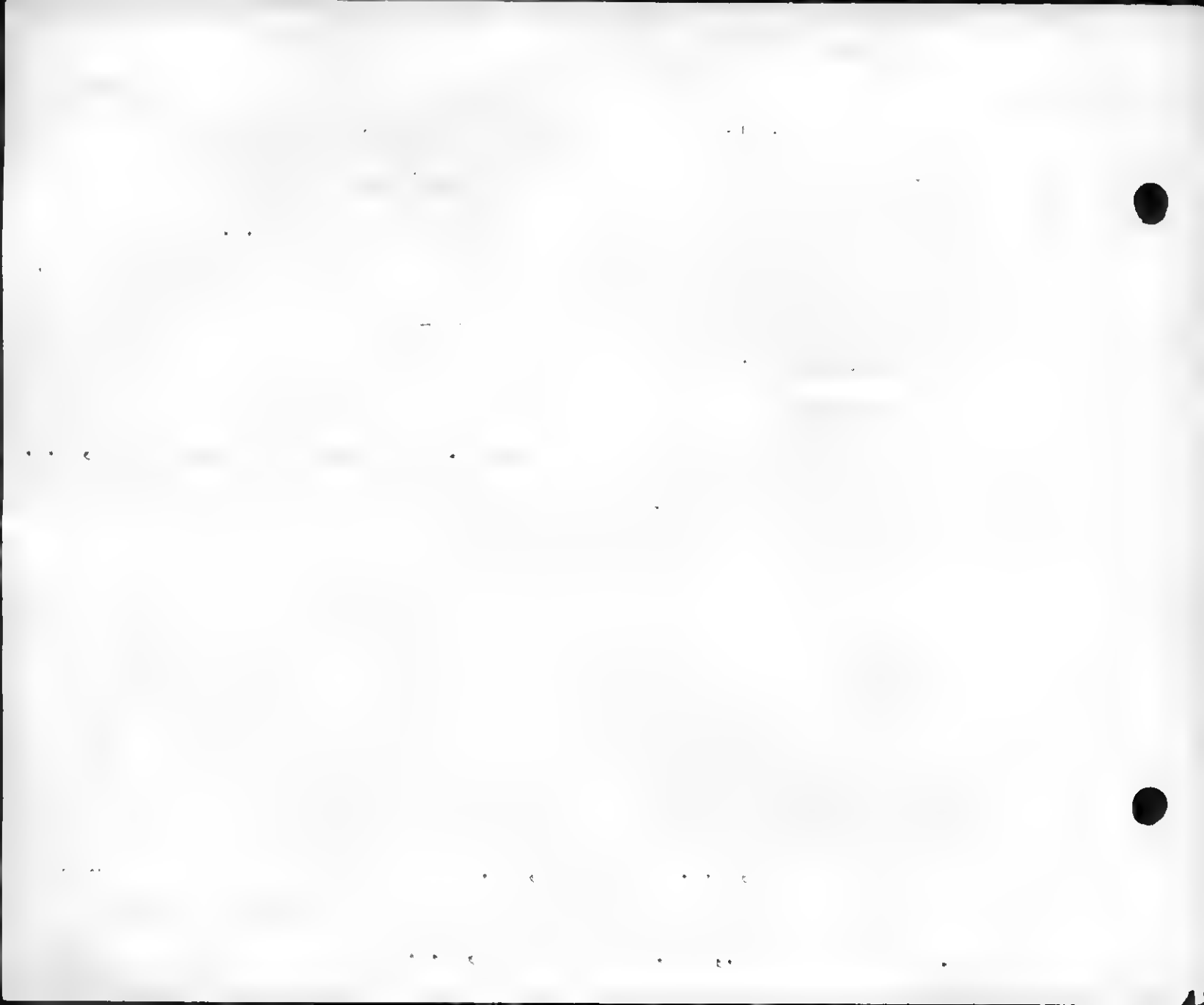
VR A15ME
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17534

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District Of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chamber's Funeral Home		d. STREET ADDRESS 1147 Morse Street N.E.	
3 NAME OF DECEASED (Type or print) First Middle Last John Lemuel Littleford		4 DATE OF DEATH Month Day Year 12 13 19 67	
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-19-1903
9 AGE (In years last birthday) 64 yrs		F UNDER 1 YEAR F UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of work no life even if retired) Landscape Gardener		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Unknown		14 MOTHER'S MAIDEN NAME Rose Manga	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Ida B. Littleford		Address 1147 Morse Street, N.E.	
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure x200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH minutes unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED 12-14-67	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 12/18/1967	23c. NAME OF CEMETERY OR CREMATORY Carver	23d. LOCATION (City or Town) (County) (State) Beltsville, Maryland
24. FUNERAL DIRECTOR W. Ernest Jarvis Co., Inc.		25a. REC'D BY REGISTRAR DEC 18 1967	
ADDRESS 1432 U Street, N.W.		25b. REGISTRAR'S SIGNATURE 	



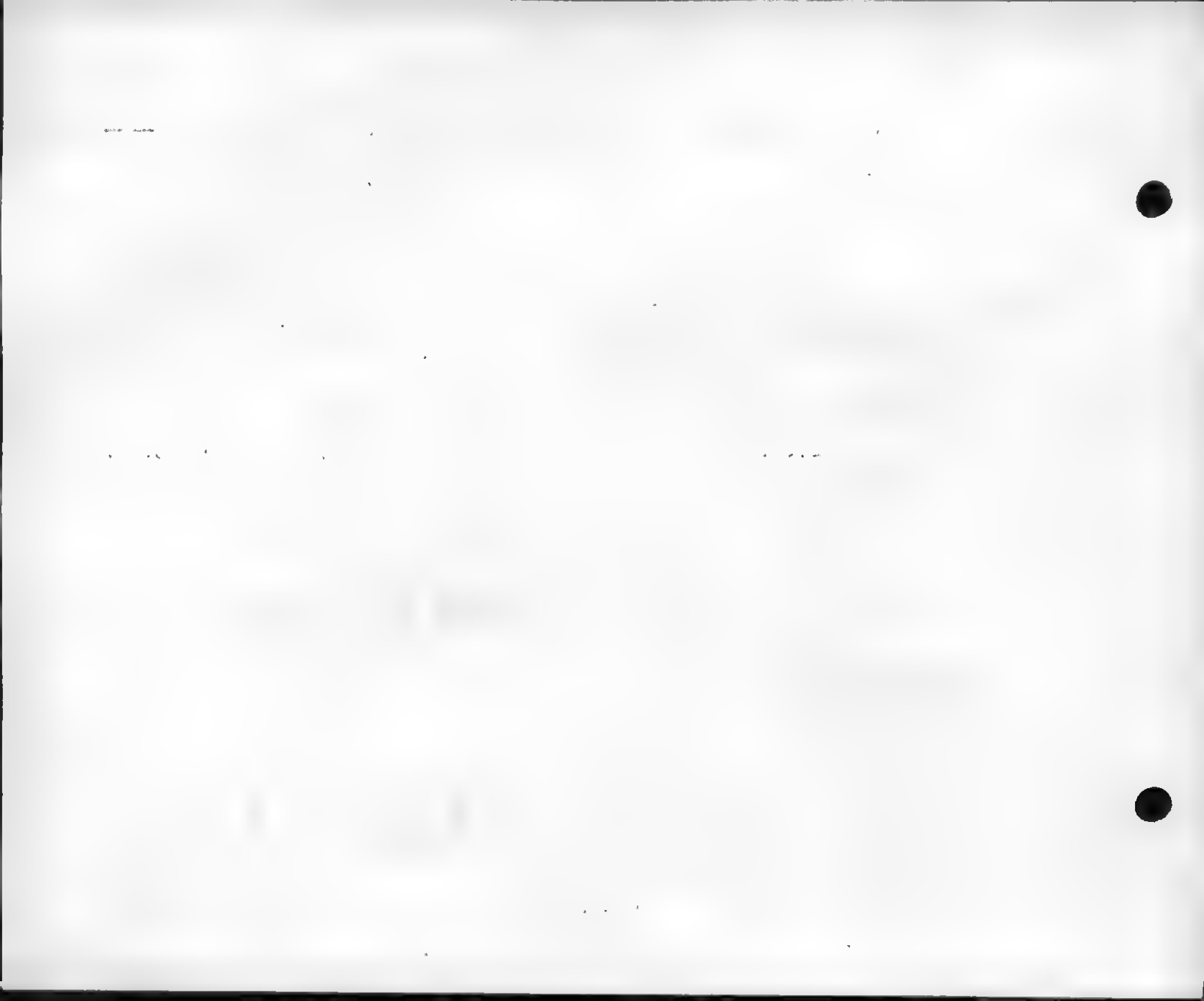
CERTIFICATE OF DEATH

17535

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville		c. LENGTH OF STAY IN 1b N/A	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Regent Nursing Home		d. STREET ADDRESS 5063 Macomb Street, N.W.	
3. NAME OF DECEASED (Type or print) Joanna K Lockhart		4. DATE OF DEATH Month Dec. Day 14 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1878
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done in most of your life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles M. Mix		14. MOTHER'S MAIDEN NAME Rose Kenyon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Lee Engdahl, 1413-33rd St, NW, Wash, DC		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH 1 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Apr. 14 , 19 60 , to Dec. 14 , 19 67 , that (I) (we) last saw the deceased alive on Dec. 12 , 19 67 , and that death occurred at 7:00 P.M. from causes and on the date stated above.			
22a. SIGNATURE Frank J. Fedor		22b. DATE SIGNED Dec. 14, 1967	
22c. PHYSICIAN'S NAME (Type) Frank J. Fedor		22d. ADDRESS m.o. 4201 Cathedral Ave. N.W. Wash. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 12/15/67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	23d. LOCATION (City or Town) (County) (State) Suitland, Maryland
24. FUNERAL DIRECTOR Jos. Gawler's Sons, 5130 Wis. Ave, Washington, D.C.		25a. REC'D BY REGISTRAR DEC 18 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

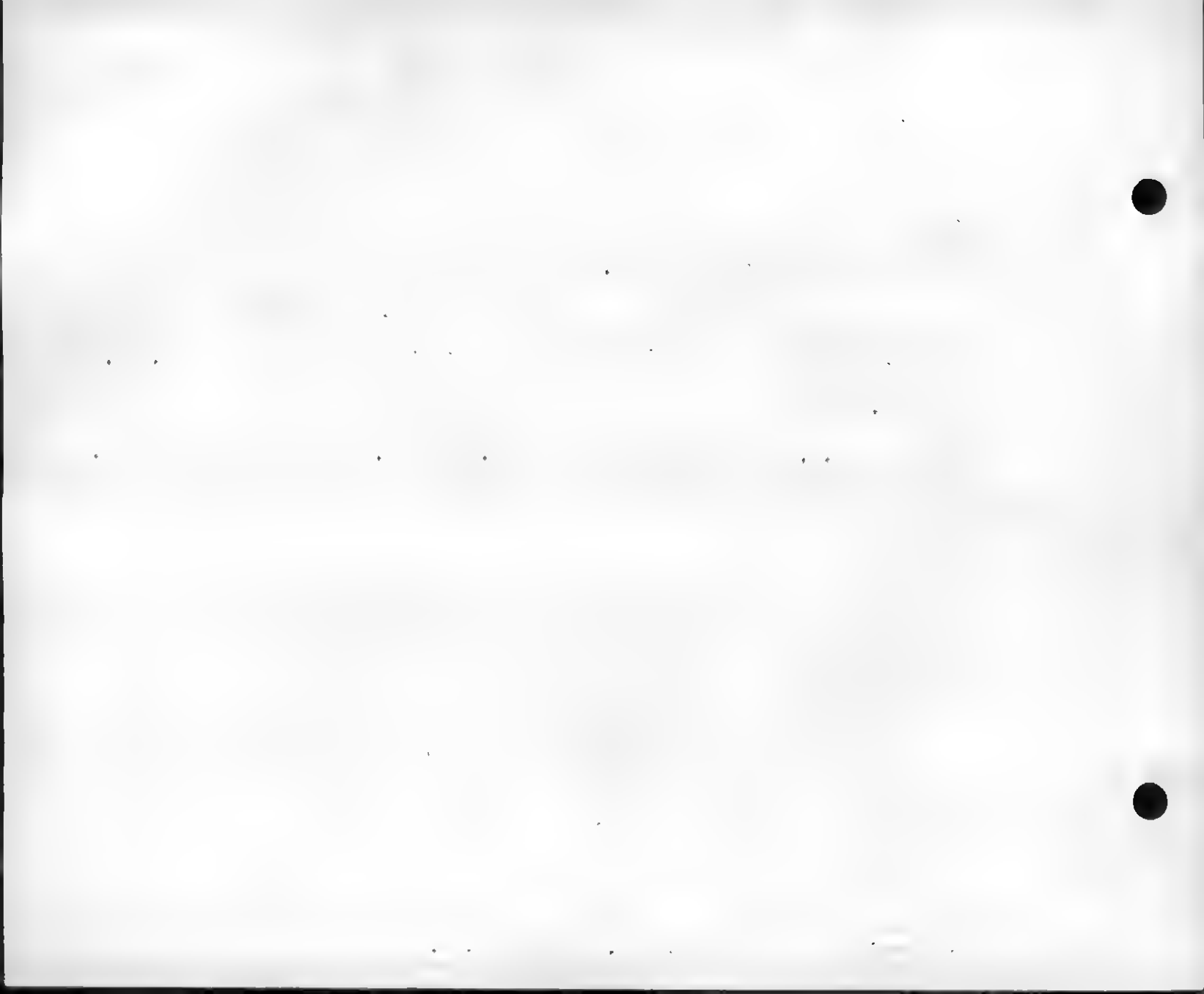
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon plates 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17536

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE VIRGINIA b. COUNTY ✓	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FORESTVILLE		c. LENGTH OF STAY IN 1b 5 days.	
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Alexandria		d. STREET ADDRESS 3105 Calvin St.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Regent Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ARNET J. Ludlow		4. DATE OF DEATH Month Day Year 12 23 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1-1-1909
9. AGE (In years last birthday) 68 yrs		10. IF UNDER 1 YEAR Months Days Hours Min 12 23 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed		10b. KIND OF BUSINESS OR INDUSTRY Service Station	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James A. Ludlow		14. MOTHER'S MAIDEN NAME Nannie Adams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W. 1		16. SOCIAL SECURITY NO. 225 10 0294	
17. INFORMANT Mr. Emory W. Ludlow, Alexandria, Va.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF Colon c Metastasis 1030 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO DUE TO		INTERVAL BETWEEN ONSET AND DEATH 12 mos	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED Where <input type="checkbox"/> Not Where <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12-19-1967 to 12-23-1967 , that (I) (we) last saw the deceased alive on 12-21-1967 , and that death occurred at 7:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE W.B. Sheer		22b. DATE SIGNED 12-23-67	
22c. PHYSICIAN'S NAME (Type) WALTER B. SHEER MD		22d. ADDRESS 6400 MARLBORO PIKE S.E. WASH. DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/27/1967	23c. NAME OF CEMETERY OR CREMATORY Mount Comfort Cemetery	23d. LOCATION (City or Town) (County) (State) Fairfax County, Virginia
24. FUNERAL DIRECTOR The Demaine Funeral Homes, Inc. Alexandria, Va.		25a. REC'D BY REG. STRAR DATE DEC 28 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>14912th HALLWAY</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Olive G LYON</u>				4. DATE OF DEATH <u>28</u> <u>19</u> <u>67</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-1-1873</u>	9. AGE (In years last birthday) <u>94</u> yrs	10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Charles County Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>
13. FATHER'S NAME <u>John H. Miller</u>				14. MOTHER'S MAIDEN NAME <u>Margaret J. Hatcher</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>John H. MITTON - 1736 Holly St N.W.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE PULMONARY EDEMA</u> 4200 DUE TO (b) <u>ARTERISCLEROTIC HEART DISEASE</u> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							19. INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>RHEUMATOID ARTHRITIS</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1</u> , 19 <u>67</u> to <u>Dec. 28</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>DEC 28</u> 19 <u>67</u> , and that death occurred at <u>3:35</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Thomas F. Collins</u>					22b. DATE SIGNED <u>12/28/67</u>		22c. PHYSICIAN'S NAME (Type) <u>THOMAS F. COLLINS</u>
22d. ADDRESS <u>322 - H. D. NE.</u>							
23a. BURIAL, CREMATION, REMOVA. (Specify) <u>Burial Dec-30-67</u>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>Chapel Point Rd</u>		23d. LOCATION (City or town) (County) (State)	
24. FUNERAL DIRECTOR <u>Sumner Bros</u>				25a. REC'D BY REGISTRAR <u>JAN 3 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



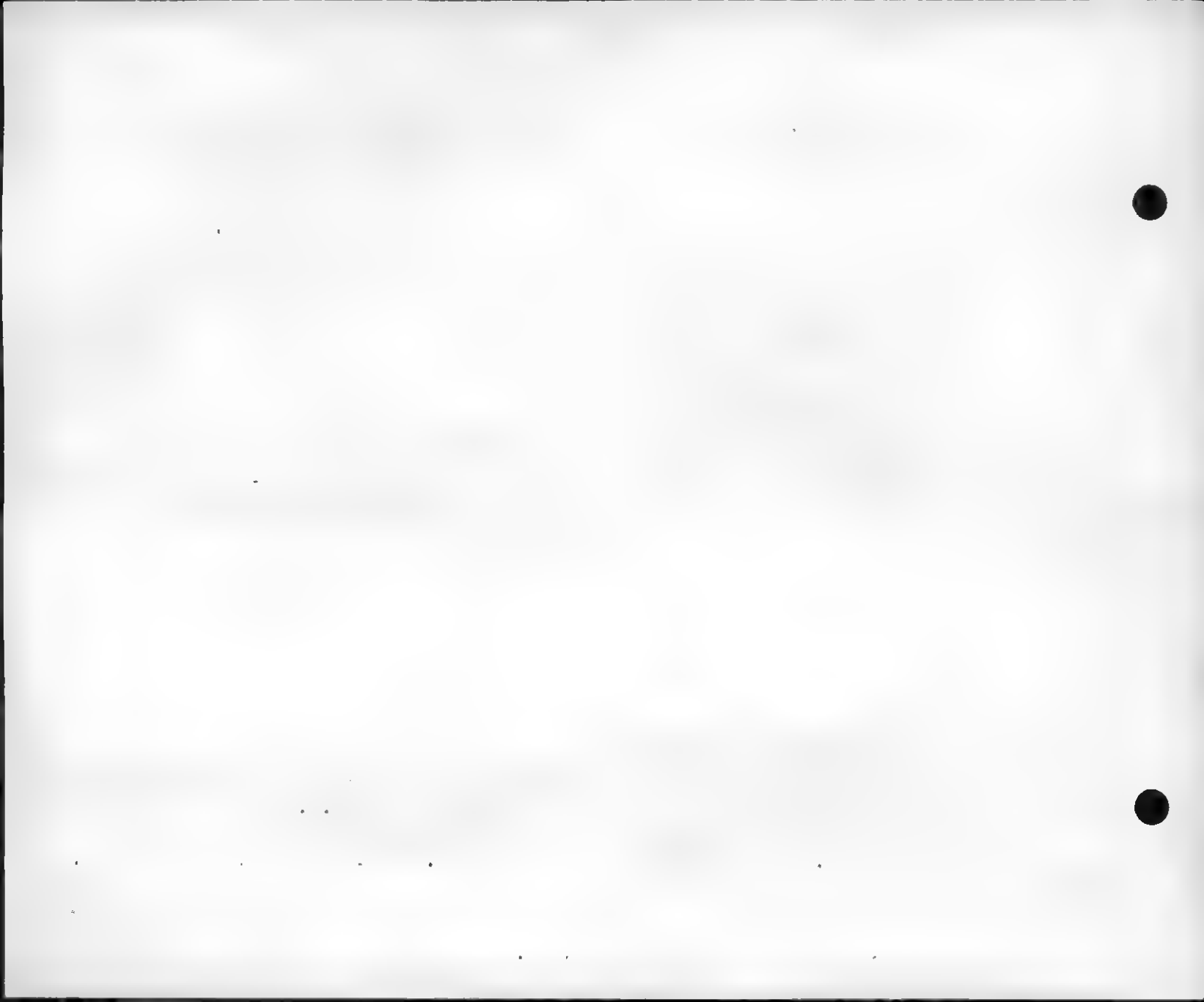
VR A15
25M 1/6

5/1/87

CERTIFICATE OF DEATH

1.538

1. PLACE OF DEATH a. COUNTY Prince George's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland		b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY in 1b 17 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seabrook			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 9522 Washington Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Catherine		First G		Middle Mansfield		Last December 13 1967	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/11/27/27	
9. AGE (In years last birthday) 39 yrs		10. UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY home			
13. FATHER'S NAME Rev Harry W Sisk				14. MOTHER'S MAIDEN NAME Norabelle Bartee			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO		17. INFORMANT Arthur L Mansfield Address Seabrook, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkin's Disease in the Posterior mediastinum DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atelectasis of the right lung DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/26 , 19 67 , to 12/13 , 19 67 , that (I) (we) last saw the deceased alive on 12/13 19 67 , and that death occurred at 6:10 M , from causes and on the date stated above							
22a. SIGNATURE Dr. Till Bergemann				ATTENDING PHYS <input type="checkbox"/> MED. P.M. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 12/14/67	
22c. PHYSICIAN'S NAME (Type) Dr. Till Bergemann				22d. ADDRESS Prof. Bldg. Centerway, Greenbelt, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 16, 1967		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or town) (County) (State) Colmar Manor Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR DEC 19 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



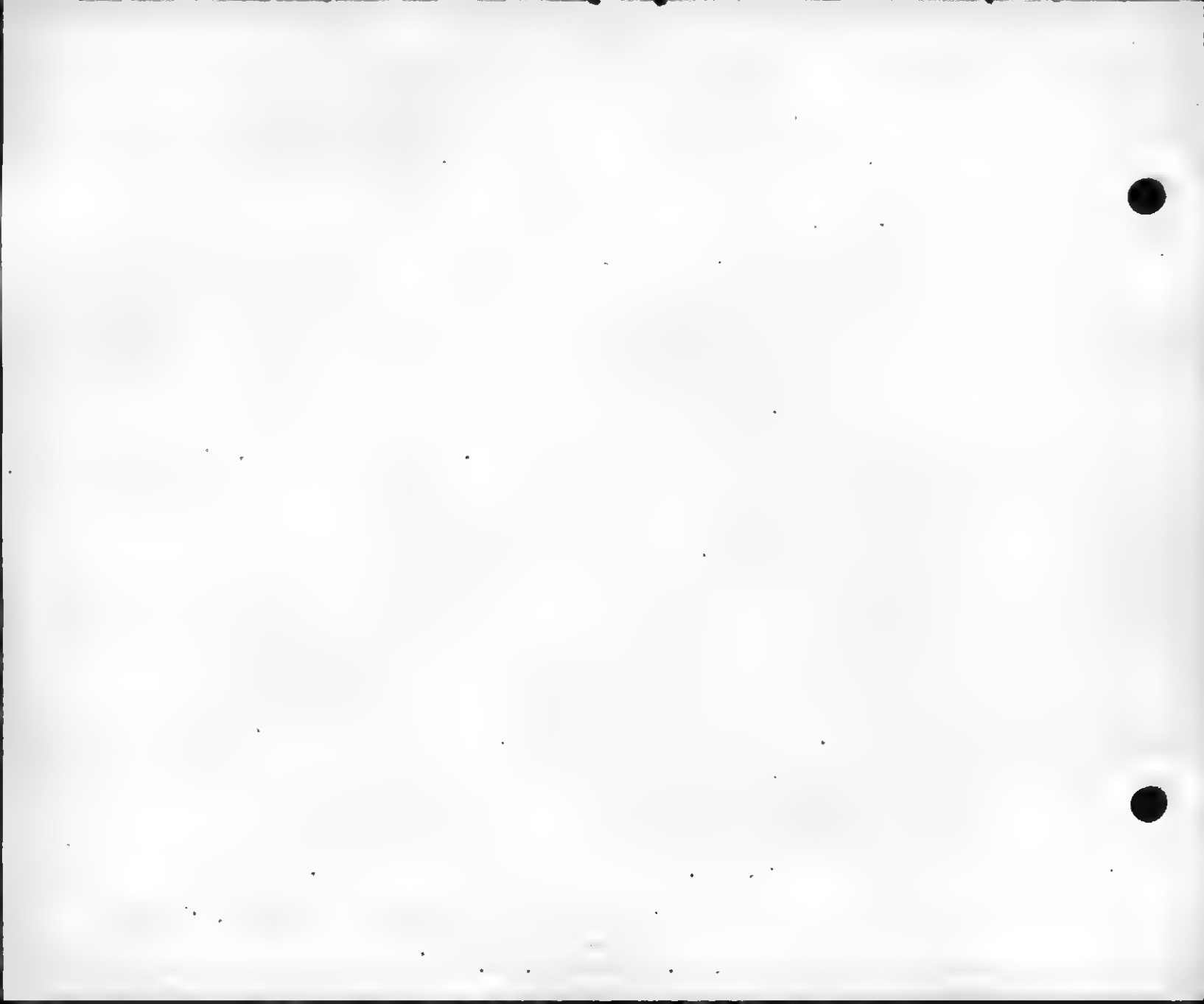
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11539

1. PLACE OF DEATH a. COUNTY Prince George's		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 5 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George's		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt		d. STREET ADDRESS 53 R Ridge Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Alvin Levi Martin		4. DATE OF DEATH Month Day Year December 21 1967		5. SEX male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Sept. 25, 1930		9. AGE (In years last birthday) 37 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Automobile		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles L. Martin		14. MOTHER'S MAIDEN NAME Ella Irey		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes give war or dates of service)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT John I. Divers		Address Vienna, Virginia		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia 1100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) AND Burns--60% of body surface DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days 5 days		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Burned in bed in fire of unknown origin		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. Noon Dec. 16 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) see 2 a		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 12-23-67	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 12-23-67		ACTUAL SIGNATURE John Kehoe		M.D. John Kehoe, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/26/67		23c. NAME OF CEMETERY OR CREMATORY Stonewall Memory Gardens	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/26/67		23c. NAME OF CEMETERY OR CREMATORY Stonewall Memory Gardens		23d. LOCATION (City, town or county) (State) Manassas, Virginia		24. FUNERAL DIRECTOR B. C. Mountcastle		25a. REC'D BY REGISTRAR DEC 27 1967		25b. REGISTRAR'S SIGNATURE J. W. Judge		Cunningham Funeral Home, Inc. Alexandria, Va.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17536

CERTIFICATE OF DEATH

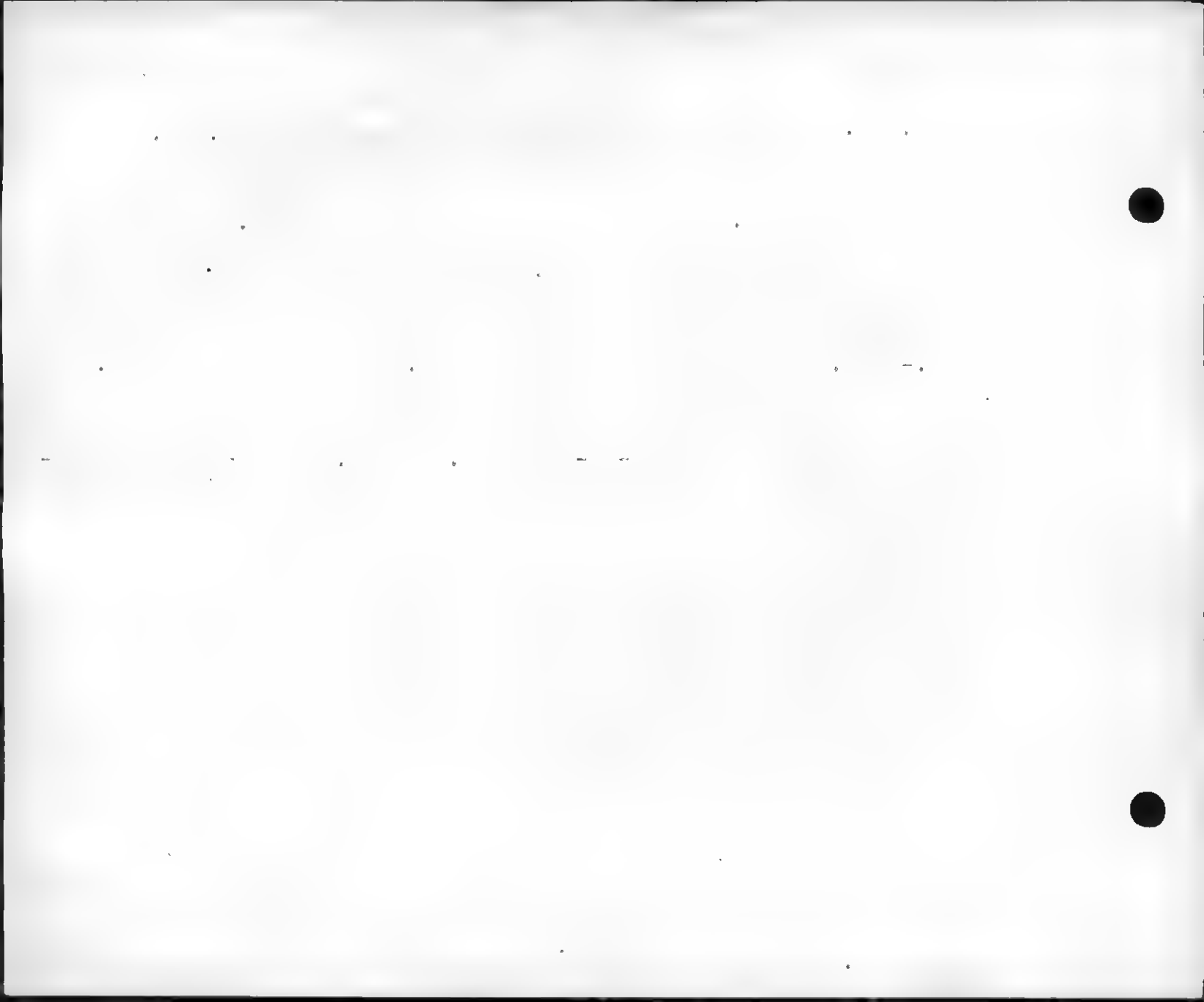
17540

1 PLACE OF DEATH a. COUNTY Pr. Geo. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chillum c. LENGTH OF STAY IN 1b 17 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5406 - 13th Ave.		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chillum d. STREET ADDRESS 5406 - 13th Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) William E. McCarten First Middle Last		4 DATE OF DEATH Month Day Year Dec. 19 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2/6/1899 9 AGE (In years last birthday) yrs 68
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.- Met. & Cap. Police		10b. KIND OF BUSINESS OR INDUSTRY Wash., D.C.	
11 BIRTHPLACE (County & State or foreign country) U.S.A.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James McCarten		14 MOTHER'S MAIDEN NAME Ellen Hughes	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI		16 SOCIAL SECURITY NO. 213-38-0430	
17. INFORMANT Mrs. Hazel M. McCarten (above address)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1771 Asthenia IMMEDIATE CAUSE (a) Due to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral & prostate (c) 2 1/2 yrs.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Coronary artery heart disease		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1962 , 19 to 12/19/67 , 19, that (I) (we) last saw the deceased alive on 12/6/67 , 19, and that death occurred at 12/19/67 M, from causes and on the date stated above			
22a. SIGNATURE Bernard J. Walsh M.D.		22b. DATE SIGNED 12/19/67	
22c. PHYSICIAN'S NAME (Type) Bernard J. Walsh		22d. ADDRESS 1800 Eye St., N.W. Washington, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/23/67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland, Md.
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25a. REC'D BY REGISTRAR DEC 29 1967	
25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION
Bernard J. Walsh
 M.D.
 12/19/67



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17541

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
c. LENGTH OF STAY IN 1b 4-1/2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover Apt. 204	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 3416 Dodge Park Road	
3 NAME OF DECEASED (Type or print) First Middle Last James Arden McClung		4 DATE OF DEATH Month Day Year Dec. 22, 1967	
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Jan. 2, 1912
9. AGE (in years last birthday) 55 yrs		IF UNDER 1 YEAR Months Days Hours Min 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Railroad		10b. KIND OF BUSINESS OR INDUSTRY New York Central	
11 BIRTHPLACE (County & State, or foreign country) West Virginia		12 CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James Boyed Mc Clung		14. MOTHER'S MAIDEN NAME Alice Mae McConkey	
15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO. 233 18 2494	
17 INFORMANT Hospital records		Address Cheverly, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinomatosis 162. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Bronchogenic carcinoma of the left lung DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH Many months
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS A TITOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town) (County) (State)
21. I certify that (1) the deceased attended the deceased from 11/18/67 , 19 67 , to Dec. 22, 1967 , that (1) the last saw the deceased alive on Dec. 22, 1967 , and that death occurred at 7:25 AM , from causes and on the date stated above.			
22a SIGNATURE Frederick H. Wilhelm M.D.		22b DATE SIGNED Dec. 22, 1967	
22c PHYSICIAN'S NAME (Type) Frederick H. Wilhelm, M. D.		22d ADDRESS 6319 Landover Road, Cheverly, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF Dec 26, 1967	23c NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	23d LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.
24 FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a REC'D BY REGISTRAR DATE DEC 29 1967	
		25b REGISTRAR'S SIGNATURE [Signature]	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

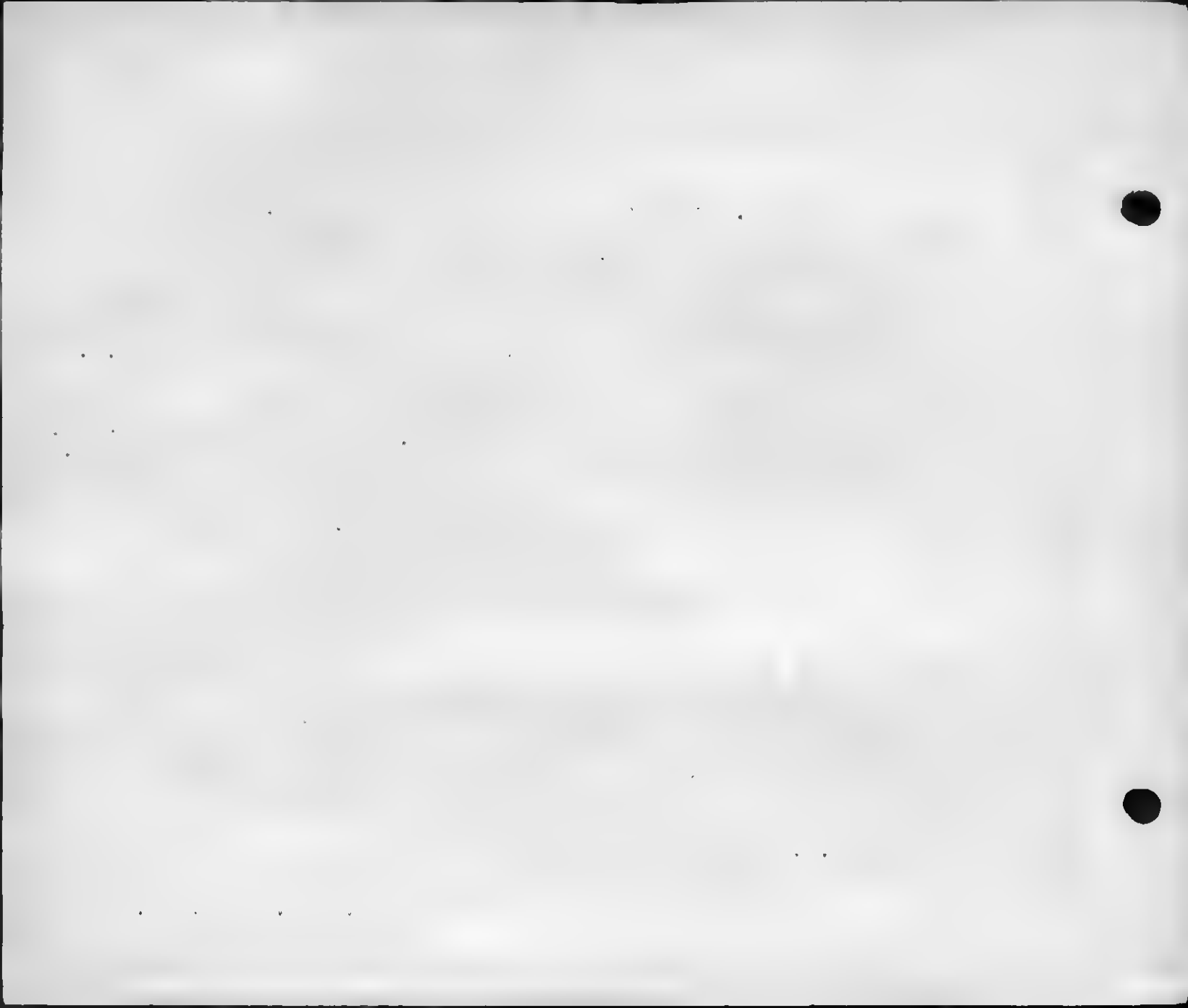
1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George Gen. Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly d. STREET ADDRESS 5706 Newton St.	
3. NAME OF (Type or print) Edna	First Arlene	Middle McHugh	4. DATE OF DEATH DEC 24 1967
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/28/05
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 24 Days 24 Hours 19 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waitress-Coffee Shop		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania	
11. BIRTHPLACE (County & State, or foreign country) U/S.A.		12. CITIZEN OF WHAT COUNTRY? U/S.A.	
13. FATHER'S NAME Peter Lavis		14. MOTHER'S MAIDEN NAME Catherine Tiers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Eleanor A. Mahon		Address #1 Prospect St. Plymouth, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY SCLEROSIS AND ANEMIA DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Arteriosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 30 MONTHS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from DEC 5TH, 1967 to 12-24, 1967 , that (I) (we) last saw the deceased alive on 12-23, 1967 , and that death occurred at 3:30 PM , from the causes and on the date stated above			
22a. SIGNATURE L.S. Blumenthal		22b. DATE SIGNED DEC 27 1967	
22c. PHYSICIAN'S NAME (Type) L.S. Blumenthal		22d. ADDRESS 5315 CONNECTICUT AVE NW	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 12/28/67	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. Ft. Myer, Va.	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE L.H. Prince Co 2901 14th St NW Wash DC		25a. REC'D BY REGISTRAR DEC 27 1967	
25b. REGISTRAR'S SIGNATURE Michael Judge			



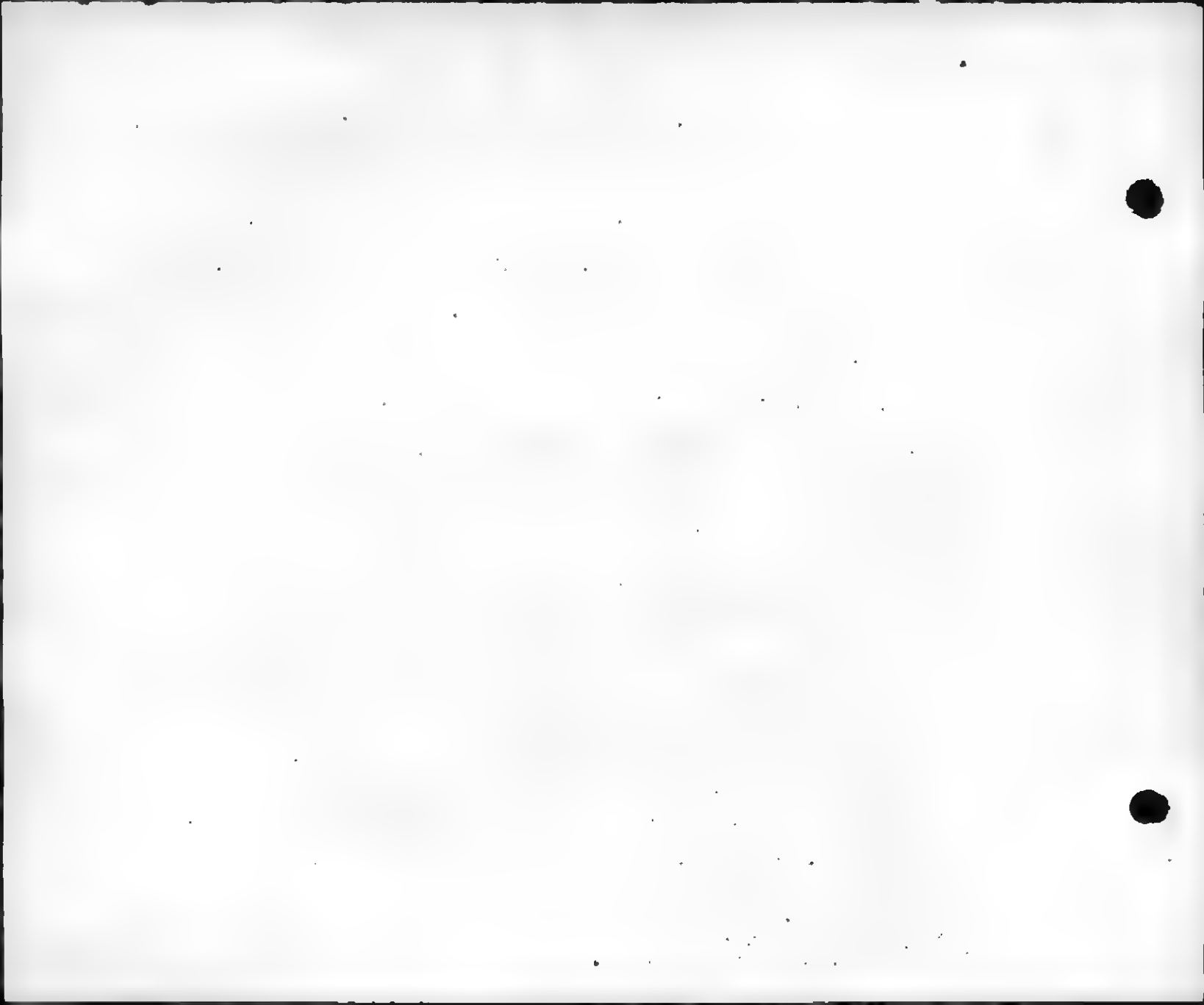
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b Bowie, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hosp.		d. STREET ADDRESS 12614—Kingsfield Lane	
3. NAME OF DECEASED (Type or print) First Middle Last FRANK W. MEDLEY, JR		4. DATE OF DEATH Dec. 3rd 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 28-1935
9. AGE (In years last birthday) 32 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Patent Examiner		10b. KIND OF BUSINESS OR INDUSTRY US Gov't	
11. BIRTHPLACE (County & State, or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Frank W. Medley, Sr		14. MOTHER'S MAIDEN NAME Julia G. Gill	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 408-529540	
17. INFORMANT Carolyn H. Medley		Address Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE HYDROTHORAX DUE TO (b) AMYLOIDOSIS DUE TO (c) RHEUMATOID ARTHRITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 6 hrs 2 YRS 15 YRS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb 18 , 19 66 , to Dec 3 , 19 67 , that (I) (we) last saw the deceased alive on Nov 28 , 19 67 , and that death occurred at 8:30 A.M., from the causes and on the date stated above.			
22a. SIGNATURE James A. Kehoo		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED Dec. 4th-1967
22c. PHYSICIAN'S NAME (Type) Dr. James A. Kehoo		22d. ADDRESS 124--19th St., N. W. Wash. DC	
23a. JOURNAL CREMATION, BURIAL (Specify)	23b. DATE THEREOF Dec. 4th 1967	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	23d. LOCATION (City, town or county) (State) Suitland, Maryland
24. FUNERAL DIRECTOR Simmons Bros		25a. REC'D BY REGISTRAR DEC 6 1967	25b. REGISTRAR'S SIGNATURE Charles Judge
24. ADDRESS Simmons Bros. 1001-Good Hope Rd SE Wash DC			

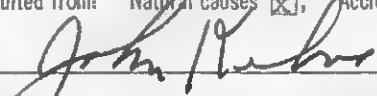
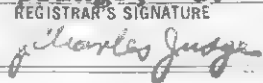


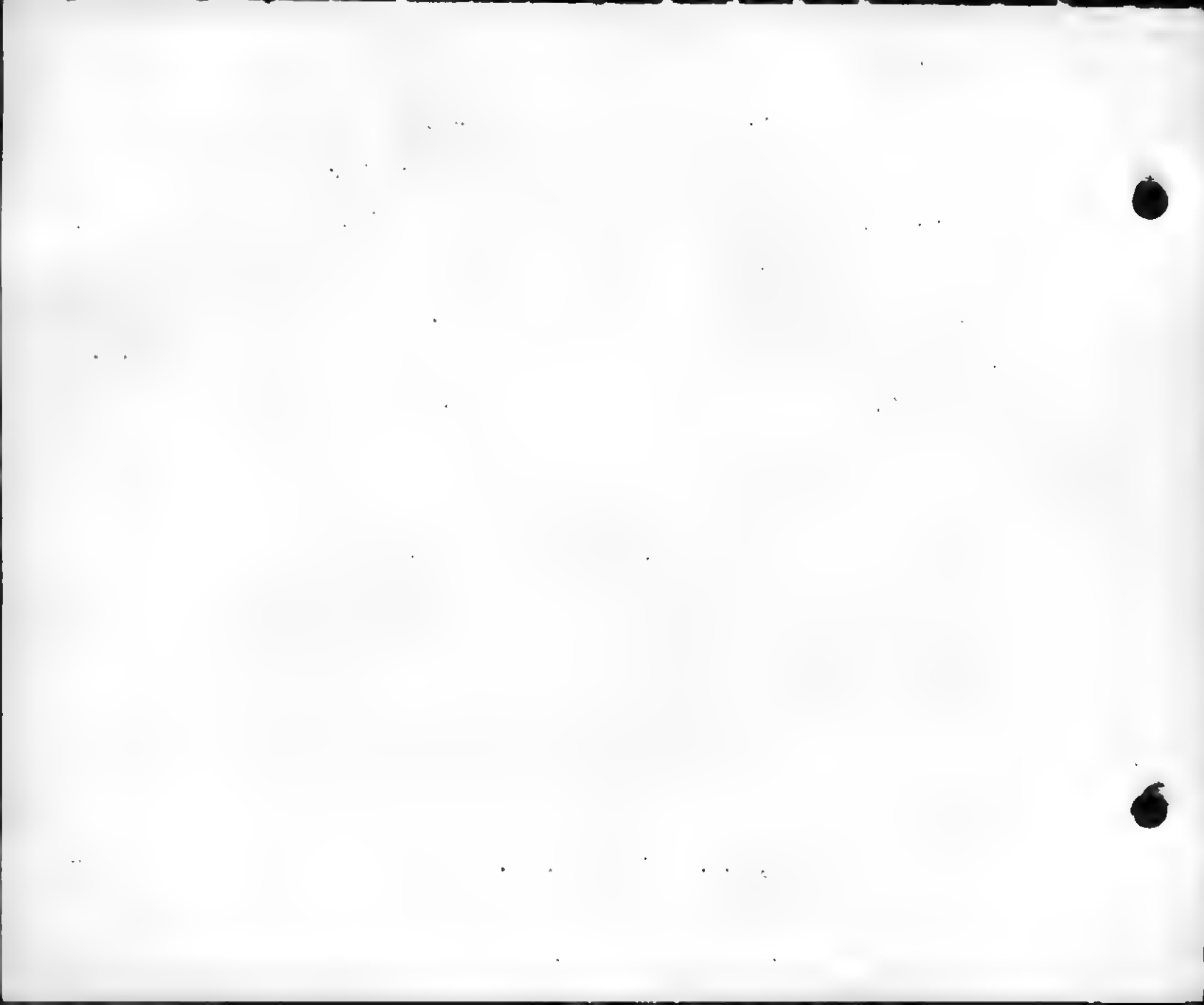
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11544

1. PLACE OF DEATH a. COUNTY Prince George's		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Maryland		c. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN ID DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carmody Hills	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 514 Carmody Hills Drive	
3. NAME OF DECEASED (Type or print) First Middle Last Dorothy Edna Meuse		4. DATE OF DEATH Month Day Year 12 25 19 67		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 Sept. 1918	9. AGE (In years last birthday) 49 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Mass.	
13. FATHER'S NAME Edward G. Burns		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Walter E. Meuse Same as 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hydrocephalus</u> DUE TO <u>Compression of brain stem</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>From adhesive arachnoiditis</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE 		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Riverdale, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-29-67		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.	
23d. LOCATION (City, town or county) Silver Springs, Md.		23e. ADDRESS Lee Funeral Home		23f. REC'D BY REGISTRAR DATE JAN 2 1968	
23g. REGISTRAR'S SIGNATURE 					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17545

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before adm ssion) a. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY in 1b 20 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS 3401 Laurel Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Nellie R. Moler			4. DATE OF DEATH Month Day Year Dec. 28, 19 67		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1899		9. AGE (In years lost birthday) 68 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) West Virginia	
13. FATHER'S NAME Albert G. Rice			14. MOTHER'S MAIDEN NAME Katherine Carter		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT James F. Mahoney Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of the head of the Pancreas DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PAGEY'S DISEASE OF BONES					19. WAS A. TOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	
		20f. (City or town)		(County) (State)	
21. I certify that (1) (the hospital) attended the deceased from 1 , 1962, to Dec. 28 , 1967, that (1) (we) last saw the deceased alive on Dec. 28 , 1967, and that death occurred at 11:30 PM , from causes and on the date stated above.					
22a. SIGNATURE <i>Donald C. Edgren</i>			22b. DATE SIGNED Dec. 29, 1967		
22c. PHYSICIAN'S NAME (Type) DONALD C. EDGREN			22d. ADDRESS Prince Georges Plaza, Hyattsville, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/2/68		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln	
				23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.			25a. REC'D BY REGISTRAR DATE JAN 4 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

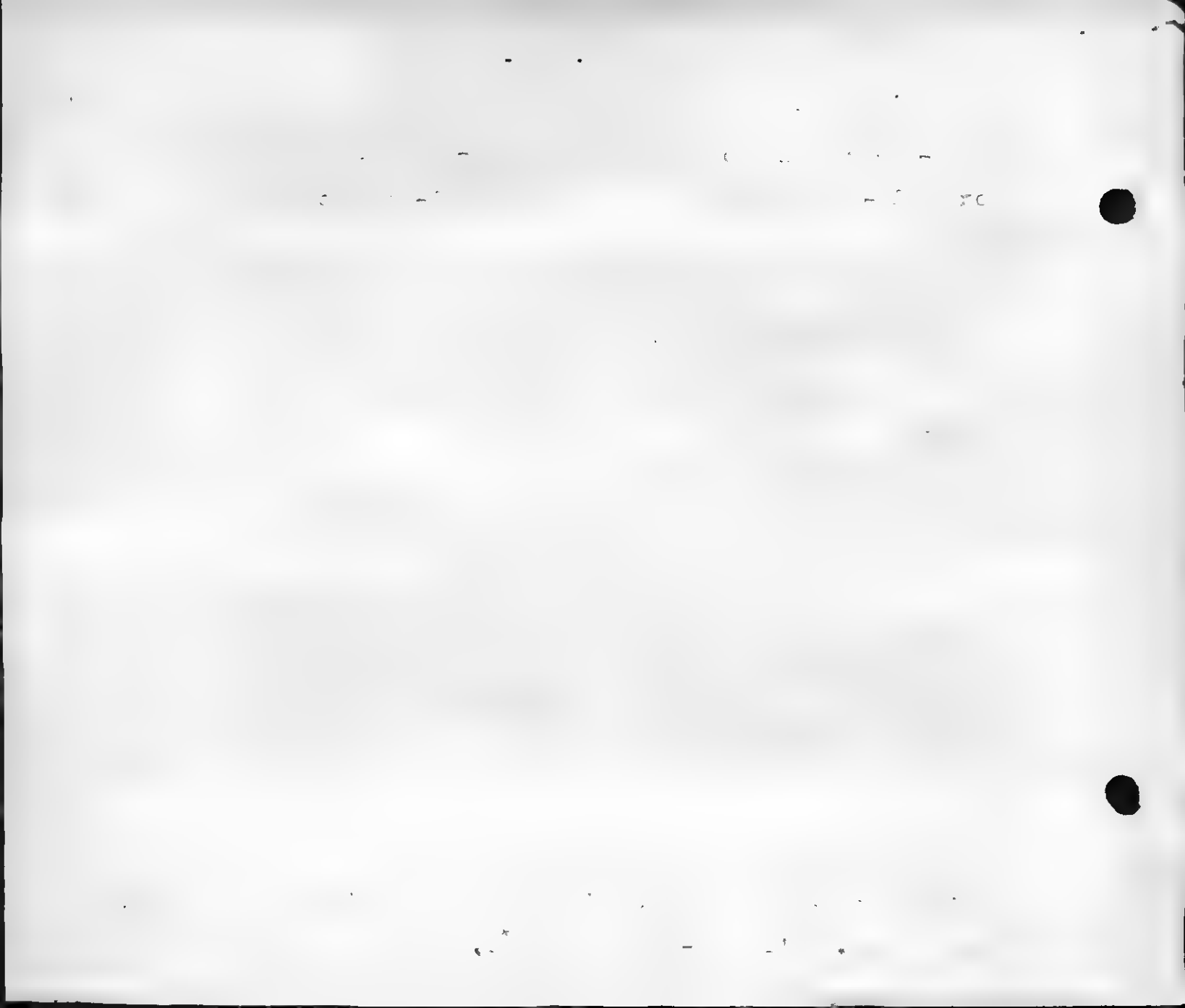


CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Geo's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-Upper Marlboro				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 4471 -Osborne Road				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) PERCY EUGENE MOORE				4. DATE OF DEATH DEC. 26 1967			
5 SEX Male	6. COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH APRIL 9, 1899	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER (Tobacco)		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ALEXANDER MOORE				14. MOTHER'S MAIDEN NAME HATTIE RYAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) Unknown		16. SOCIAL SECURITY NO.		17. INFORMANT Don Moore Address Box 4027, Upper Marlboro			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED CARCINOMATOSIS DUE TO CARCINOMA OF SIGMOID Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)						INTERVAL BETWEEN ONSET AND DEATH 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 7, 1967 to DEC. 26, 1967 , that I last saw the deceased alive on DEC. 24, 1967 , and that death occurred at 6:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6106 OLD SILVER HILL ROAD DATE SIGNED 12-26-67							
ACTUAL SIGNATURE BENJAMIN S. PERSON		M.D. PARKLAND MARYLAND					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/29/67		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Fun'l Home-Upper Marlboro,				ADDRESS Md.		24a. REC'D BY REGISTRAR DEC 28 1967	
				24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be notified. Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



VR A15 (4)
25M 1/67

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORESTVILLE, MD.		c. LENGTH OF STAY IN 1b 6 da.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) REGENT NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle LOUISE Last MORELAND		4. DATE OF DEATH Month 12 Day 3 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-20-90
9. AGE (In years last birthday) 77 yrs		10. IF UNDER 1 YEAR Months 7 Days 7 Hours 0 Min 0	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSE		11b. KIND OF BUSINESS OR INDUSTRY	
12. BIRTHPLACE (County & State, or foreign country) Wash DC		13. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. FATHER'S NAME James Rogers Harrison		15. MOTHER'S MAIDEN NAME Mary Oshorne Welch	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		17. SOCIAL SECURITY NO 377-37686403	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis DUE TO (b) Metastatic Carcinoma of the breast DUE TO (c) 2 yrs.		19. INTERVAL BETWEEN ONSET AND DEATH 6 hrs.	
20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
23a. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		23b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
24a. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		24b. (City or town) (County) (State)	
25. I certify that (I) (this hospital) attended the deceased from 12-3 , 19 67 , to 12-3 , 19 67 , that (I) (we) last saw the deceased alive on Dec. 3 , 19 67 , and that death occurred at 4:49 P.M. from causes and on the date stated above			
26a. SIGNATURE W.B. Sheer		26b. DATE SIGNED Dec. 3, 1967	
27a. PHYSICIAN'S NAME (Type) WALTER B. SHEER		27b. ADDRESS 6400 MARLBORO PIKE SE. WASH. DC.	
28a. BURIAL, CREMATION, REMOVAL (Specify) Burial		28b. DATE THEREOF 12-6-1967	
28c. NAME OF CEMETERY OR CREMATORY Sedona Hill		28d. LOCATION (City or Town) (County) (State) Suitland, Prince Georges	
29. FUNERAL DIRECTOR Robert A. Mattingly		30. REC'D BY REGISTRAR DEC 5 1967	
31. REGISTRAR'S SIGNATURE Charles Jones		32. REGISTRAR'S SIGNATURE Charles Jones	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

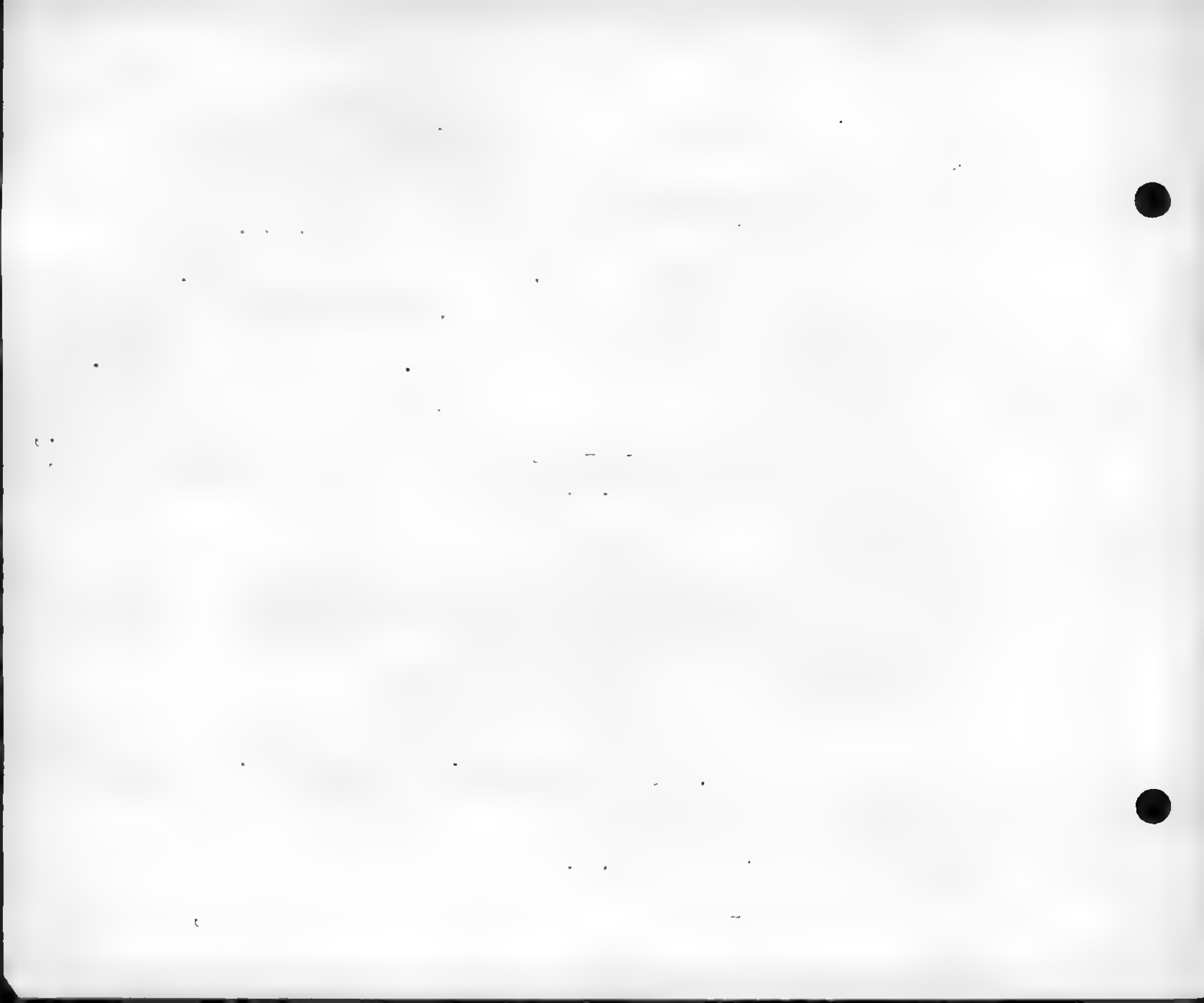
VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1:548

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY in 1b 4 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY W c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Heights d. STREET ADDRESS 6418 Lee Place, N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Whitney I Morgan		4. DATE OF DEATH Dec 21, 1967	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 25, 1918
9. AGE (In years last birthday) 49 yrs		10. IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) Trade helper		10b. KIND OF BUSINESS OR INDUSTRY County Commissionerv.	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Morgan		14. MOTHER'S MAIDEN NAME Ellen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 226-13-1038	
17. INFORMANT Mrs. Estelle Morgan		Address: 6418 Lee Pl., Cedar Heights, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443x Intracerebral Hemorrhage DUE TO (b) Pulmonary edema (c) Hypertensive Heart Disease Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 day 1 day year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that the (this hospital) attended the deceased from Dec. 17, 1967 to Dec. 21, 1967 , that he (we) last saw the deceased alive on Dec. 21, 1967 , and that death occurred at 4:25 PM , from causes and on the date stated above.			
22a. SIGNATURE <i>Till Bergemann</i>		22b. DATE SIGNED Dec 23, 1967	
22c. PHYSICIAN'S NAME (Type) Till Bergemann, M. D.		22d. ADDRESS Prince Georges General Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-27-67	23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park	23d. LOCATION (City or Town) (County) (State) Lanover, Maryland
24. FUNERAL DIRECTOR Williams Funeral Home		25a. REC'D BY REGISTRAR DEC 27 1967	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

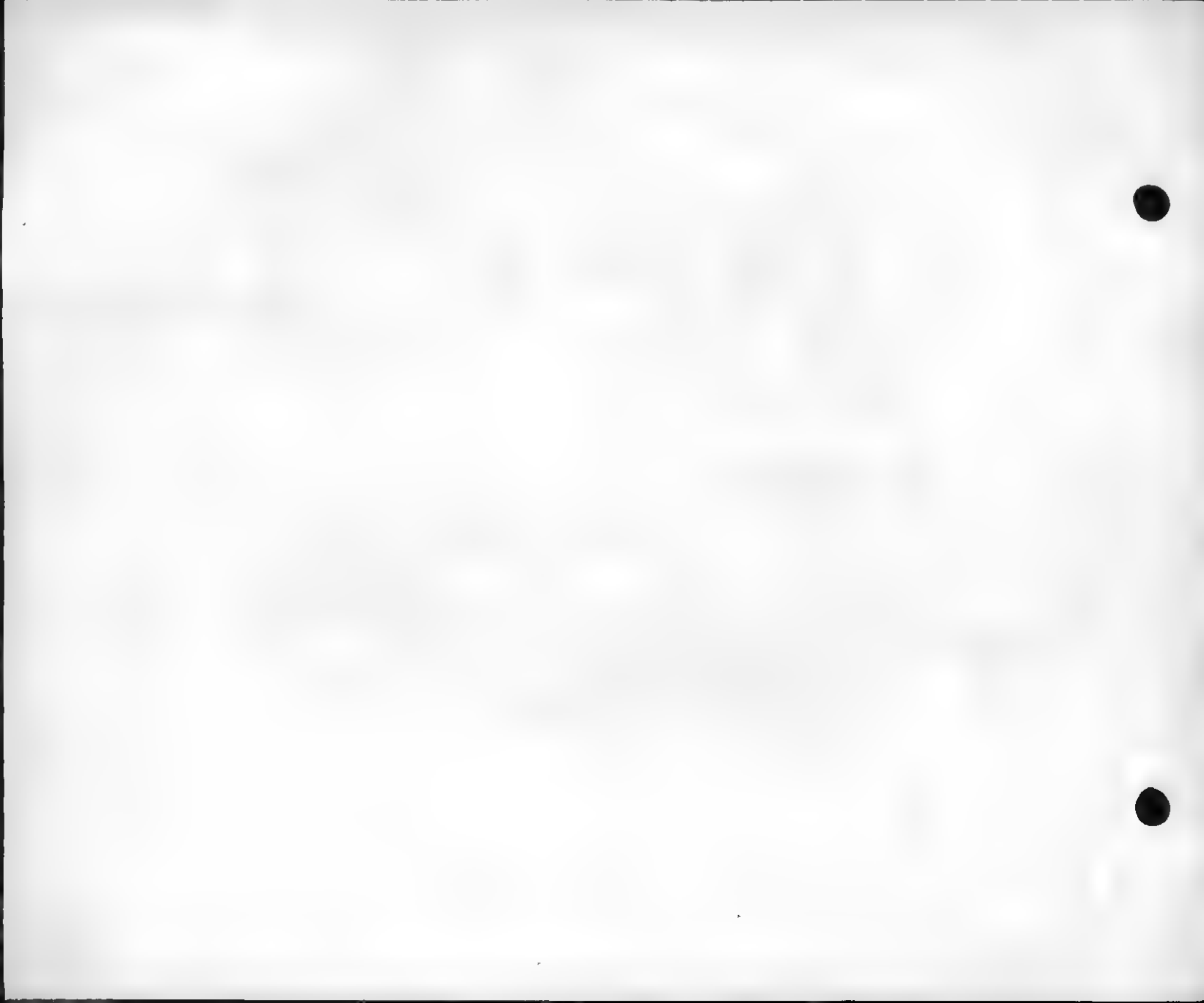
CERTIFICATE OF DEATH

11549

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Pro Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) University Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) University Park			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6901 Pineway				d. STREET ADDRESS 6901 Pineway			
3. NAME OF DECEASED (Type or print) First Middle Last Waldo Briggs Moyers				4. DATE OF DEATH Month Day Year Dec 9, 19 67			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 17, 1900	9. AGE (In years last birthday) yrs 67	10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician			10b. KIND OF BUSINESS OR INDUSTRY own practice		11. BIRTHPLACE (County & State or foreign country) Mathias, West Virginia		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Benjamin Franklin Moyers				14. MOTHER'S MAIDEN NAME Sallie Pawley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) yes W W I			16. SOCIAL SECURITY NO. 217 368 099A		17. INFORMANT Elinor C Moyers Address University Park, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 177X DUE TO CHLOROMINIOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) CANCER OF PROSTATE (c) CHLOROMINIOSIS						INTERVAL BETWEEN ONSET AND DEATH 1 yrs 6 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept 1966 to 12/9 1967 , that (I) (we) last saw the deceased alive on 12/9 1967 , and that death occurred at 4 PM , from causes and on the date stated above							
22a. SIGNATURE Norman D. Dantz				22b. DATE SIGNED 12/9/67		22c. PHYSICIAN'S NAME (Type) Norman D. Dantz	
22d. ADDRESS 3563 Perry St Mt Vernon Md				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 11, 1967		23c. NAME OF CEMETERY OR Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons				25a. REC'D BY REGISTRAR DEC 13 1967		25b. REGISTRAR'S SIGNATURE [Signature]	
ADDRESS Hyattsville, Md.				DATE			



17550

VR A15 (4)
25M 1/67

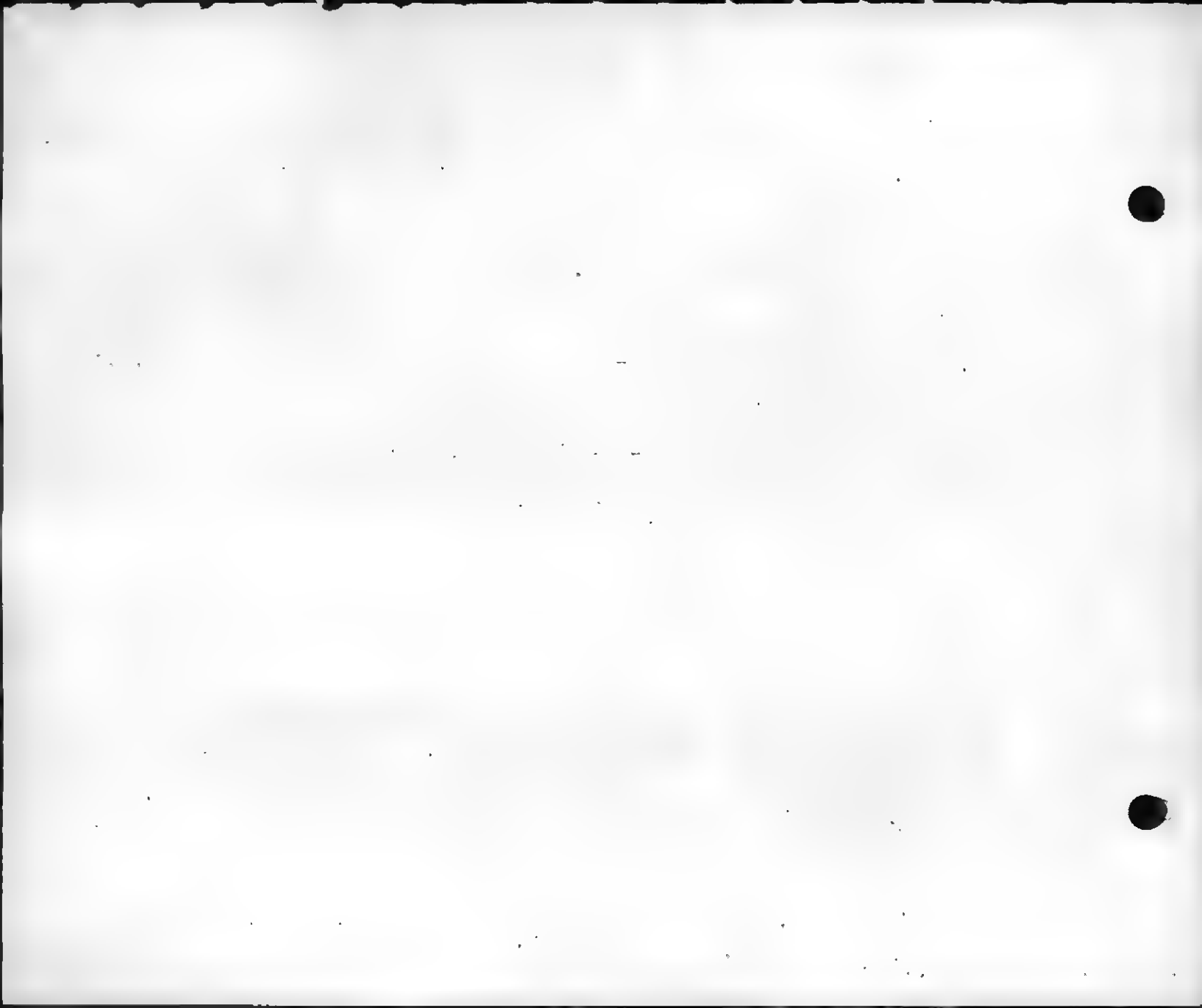
1902 - 1903

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>			c. LENGTH OF STAY IN 1b <u>4 days</u>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's General Hospital</u>						d. STREET ADDRESS <u>4703 25th Street</u>	
3. NAME OF DECEASED (Type or print) <u>Frances M. Nockles</u>				4. DATE OF DEATH <u>Dec. 25 1967</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 29, 1873</u>	
9. AGE (in years last birthday) <u>94 yrs.</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Scotland</u>	
13. FATHER'S NAME <u>William Birtwell</u>				14. MOTHER'S MAIDEN NAME <u>Janete Morrison</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-54-8084</u>		17. INFORMANT <u>Miss Alice Nockles (above address)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>794 X</u> OUE TO (b) <u>Old Age</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/21</u> , 19 <u>67</u> , to <u>12/25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>4:45</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Arnold E. Brady</u>				22b. DATE SIGNED <u>12/25/67</u>		22c. PHYSICIAN'S NAME (Type) <u> </u>	
22d. ADDRESS <u> </u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/28/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Riverside Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Saugus, Mass.</u>	
24. FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u>				25a. REC'D BY REGISTRAR <u> </u>		25b. REGISTRAR'S SIGNATURE <u> </u>	
				ADDRESS <u>Mt. Rainier Maryland</u>		DATE <u>DEC 28 1967</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-2, Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17552

1 PLACE OF DEATH a COUNTY <u>Prince George's</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u>				c LENGTH OF STAY IN 1b <u>DOA</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Andrew's Air Force Base Hospital</u>				e STREET ADDRESS <u>4904 R Street</u>			
3 NAME OF DECEASED (Type or print) First <u>Ulysses</u> Middle <u>Norman</u> Last <u>Norman</u>				4 DATE OF DEATH Month <u>12</u> Day <u>12</u> Year <u>19 67</u>			
5 SEX <u>Male</u>		6 COLOR OR RACE <u>Negro</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>22 March 1957</u>	
9 AGE (In years last birthday) <u>10</u> yrs		10 FUNDING YEAR Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min. <u>10</u>		11 BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>				10b KIND OF BUSINESS OR INDUSTRY <u>School</u>			
13 FATHER'S NAME <u>Ulysses V. Norman, Jr.</u>				14 MOTHER'S MAIDEN NAME <u>Eleanor M. Norman</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>None</u>				16 SOCIAL SECURITY NO <u>None</u>			
17 INFORMANT <u>Ulysses V. Norman, Sr.</u>				Address <u>Coral Hills, Md.</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO <u>Bronchial asthma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>							
20a. EXTERNAL CAUSE WAS PR. MARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Kehoe</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John Kehoe, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22. DATE SIGNED <u>12-13-67</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURLINGHAM, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>12-18-67</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>				23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>			
24 FUNERAL DIRECTOR <u>John T. Rhine</u>				25a. REC'D BY REGISTRAR <u>DEC 20 1967</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				25c. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



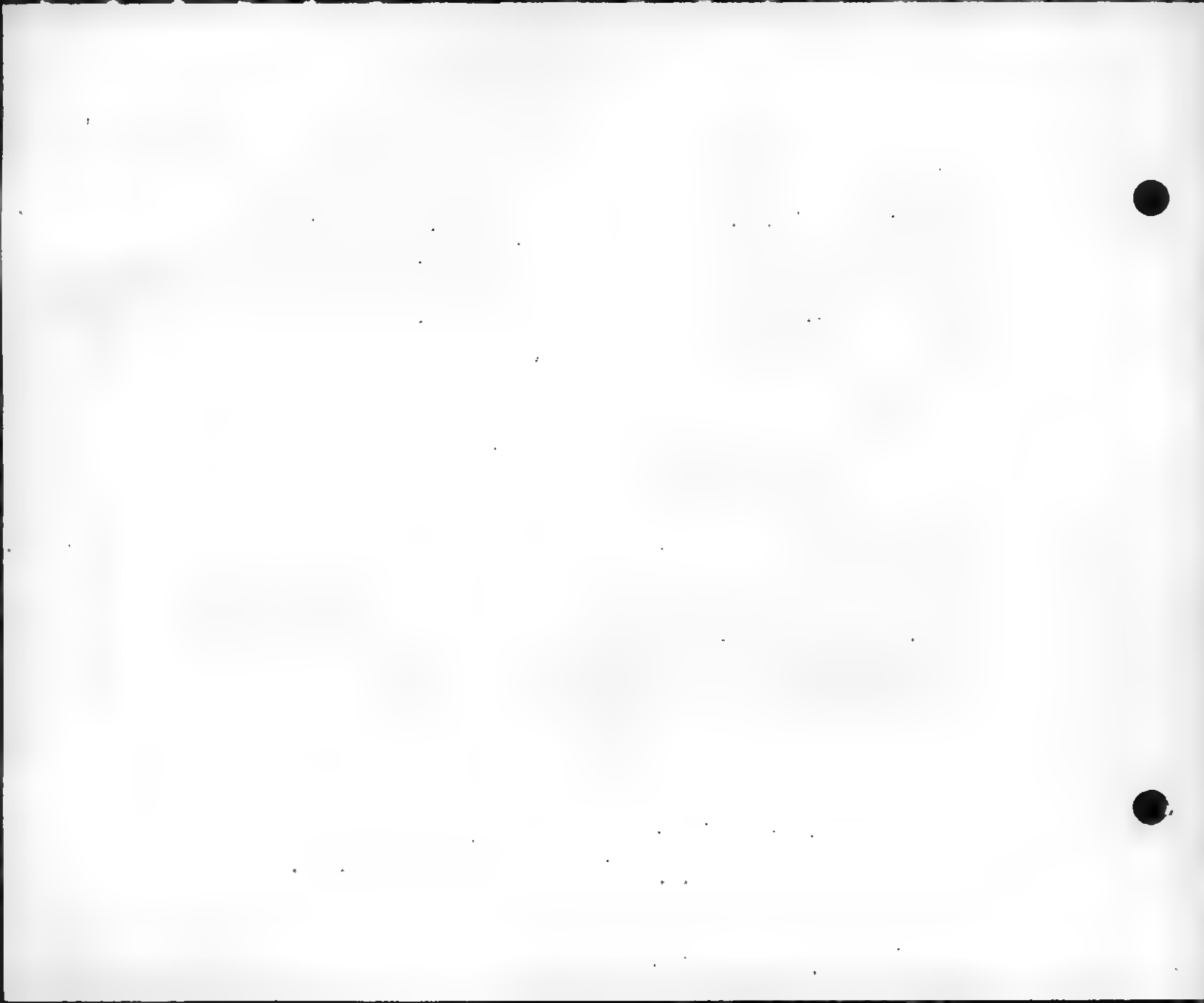
1 FOR STATE HEALTH DEPT.

TO DEPUTY MED. EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN ID DOA		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George's		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park		d. STREET ADDRESS 1205 Jackson Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John NMI		First John		Middle NMI		Last ALSO NOVICKAS Noviskas		4. DATE OF DEATH December 23 19 67		Month December		Day 23		Year 19 67	
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 24, 1889		9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER		11. BIRTHPLACE (State or foreign country) LITHUANIA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY ENG. DEPT. AKRON OHIO		11. BIRTHPLACE (State or foreign country) LITHUANIA		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 280 09 9808	
17. INFORMANT WALTER NOVAK		Address SAME AS #2		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH minutes over 2 yrs.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of rectum—two years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 12-23-67		23a. BURIAL CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC 26 1967	
23c. NAME OF CEMETERY OR CREMATORY HOLY CROSS CEM.		23d. LOCATION (City, town or county) (State) AKRON, OHIO		24. FUNERAL DIRECTOR W.W. CHAMBERS Co., RIVERDALE, MD		25a. REC'D BY REGISTRAR DATE DEC 29 1967		25b. REGISTRAR'S SIGNATURE		26. EXAMINER'S SIGNATURE John Kehoe, M.D.		27. EXAMINER'S NAME (Type) John Kehoe, M.D.		28. ADDRESS (Street, city, town, or county) Riverdale, Md	



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

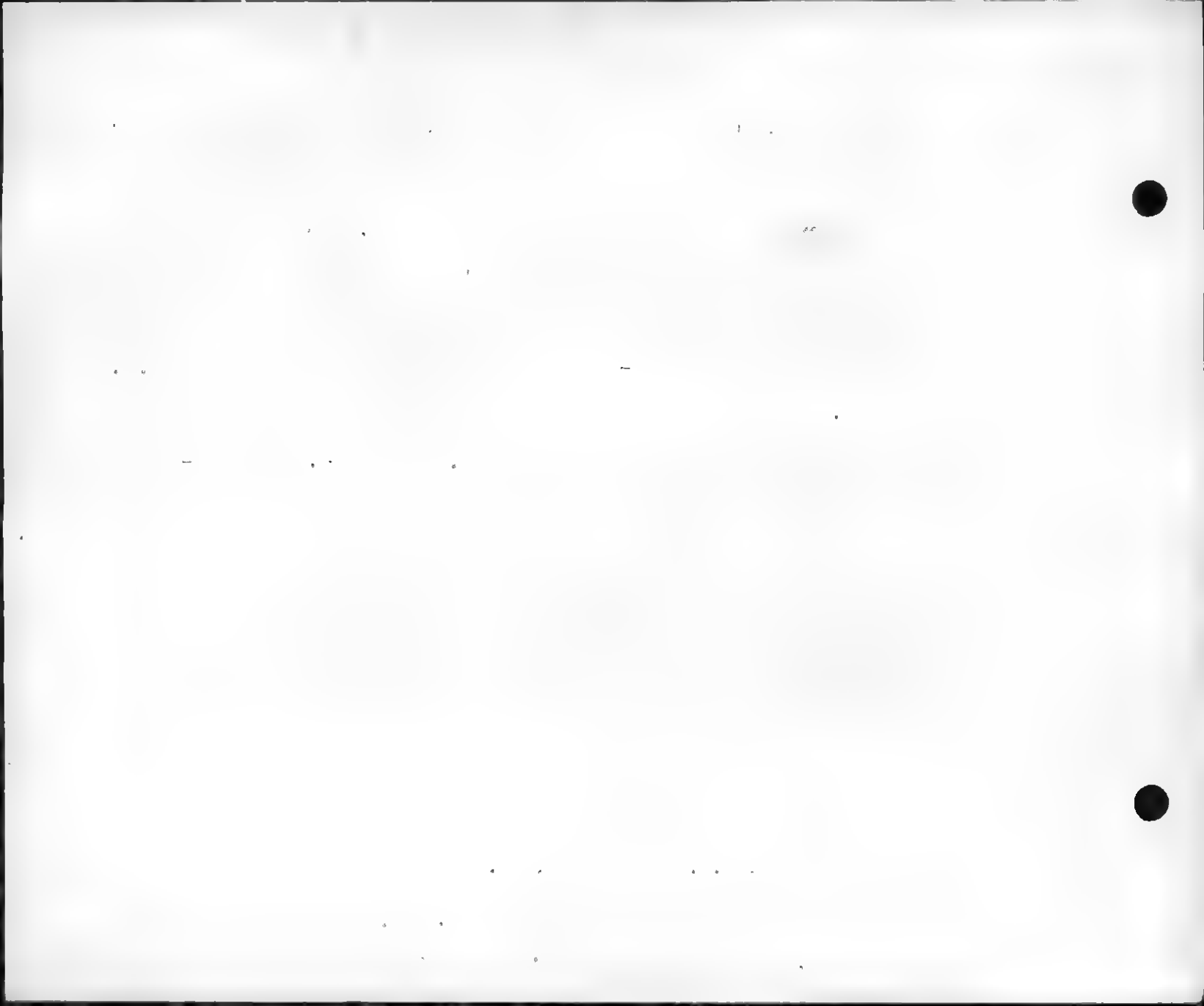
VR A15ME (5)
6M 1/67

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17554

1. PLACE OF DEATH a COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Prince George's			
b CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) Riverdale		c LENGTH OF STAY IN It DOA		c CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) Mt. Rainier		d IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital				d STREET ADDRESS 4207 28th. Street			
3 NAME OF DECEASED (Type or print) First Mattie Middle Mae Last O'Brian				4 DATE OF DEATH Month 12 Day 14 Year 1967			
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10 March 1898		9 AGE (In years last birthday) 69 yrs	10 UNDER 1 YEAR Months 12 Days 14 Hours 19 Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY -		11 BIRTHPLACE (State or foreign country) South Carolina		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Barse L. Heatley				14 MOTHER'S M A DEN NAME Elizabeth Godfrey			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 215-26-2811		17 INFORMANT Mr. Anthony A. O'Brien - St.,		Address 12811-Weiss	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Hypertensive cardio vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) over 5 yrs. (c) over 5 yrs.						INTERVAL BETWEEN ONSET AND DEATH minutes	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe		EXAMINER'S NAME (Type) John Kehoe, M.D.		M.D. Riverdale, Md.		22. DATE SIGNED 12-15-67	
23a BURIAL, CREMATION, REMOVAL, etc.		23b DATE THEREOF 12/18/67		23c NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.		23d LOCATION (City or Town) (County) (State) Arlington, Va.	
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		ADDRESS Mt. Rainier, Maryland		25a REC'D BY REGISTRAR DEC 21 1967		25b REGISTRAR'S SIGNATURE James Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

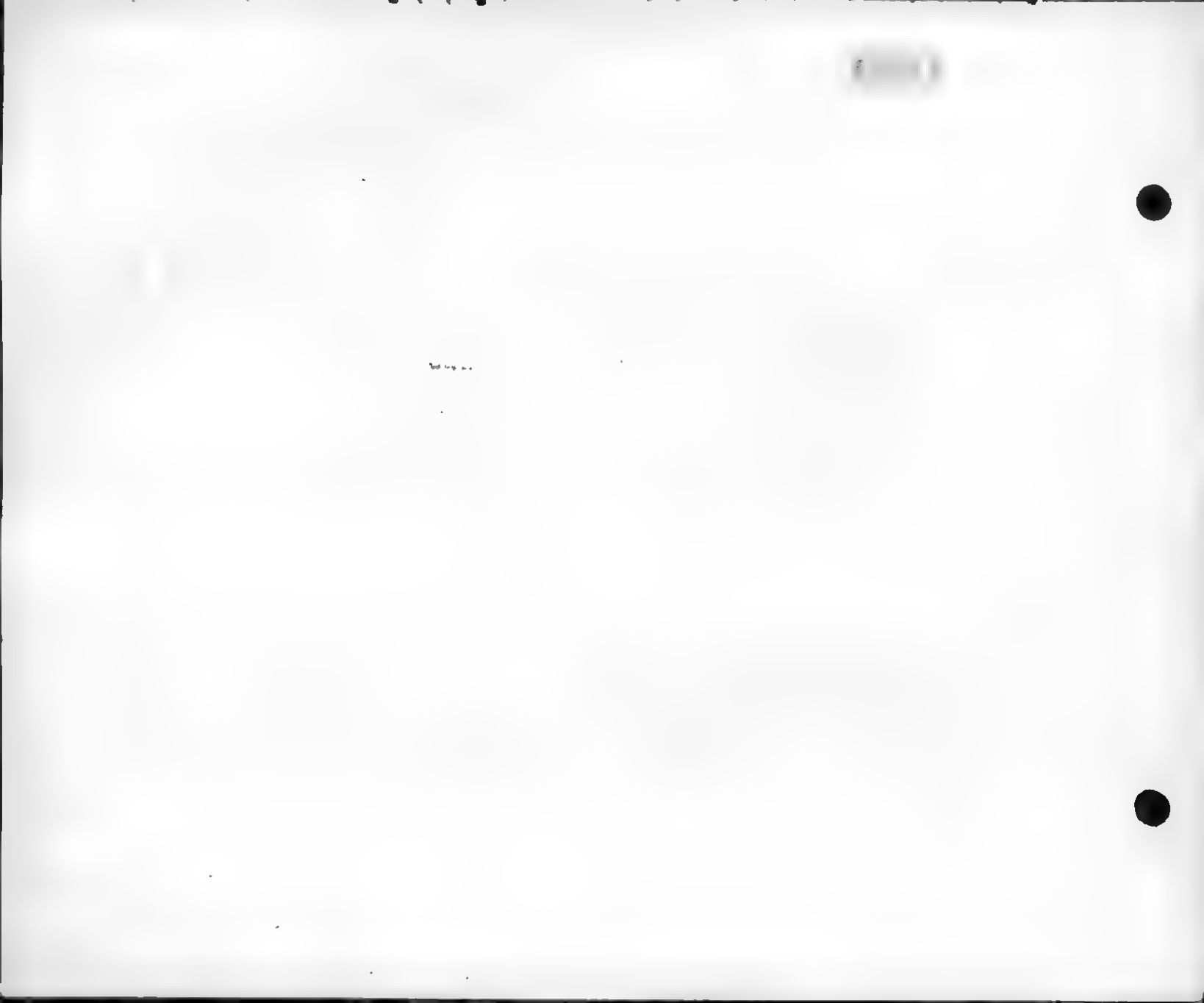
CERTIFICATE OF DEATH

17555

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN TB			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edward Middle T Last Olson				4. DATE OF DEATH Month Dec Day 15 Year 19 67			
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-17-03	9. AGE (In years last birthday) 64 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Proof Reader			10b. KIND OF BUSINESS OR INDUSTRY Printing		11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Reinhold Olson				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO No		17. INFORMANT Address Virginia Olson - Wife - #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY ARTERY DISEASE DUE TO (c) ARTERIOSCLEROSIS							INTERVAL BETWEEN ONSET AND DEATH INSTANTANEOUS 6 YEARS 07-14 YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept , 1958, to Dec 15 , 1967, that (I) (we) last saw the deceased alive on 15 DEC. 1967 , and that death occurred at 15 DEC. 1967 , and that death occurred at the date stated above.							
22a. SIGNATURE HRW				22b. DATE SIGNED 12/15/67		22c. PHYSICIAN'S NAME (Type) Harry R. Wolfe	
22d. ADDRESS 905 Sheridan St. Chillum, Md.				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/19/67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery Suitland, Pr Geo, Md.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Lee F. H., 300 4th St, NE, Wash, D.C.				25a. REC'D BY REGISTRAR DEC 21 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



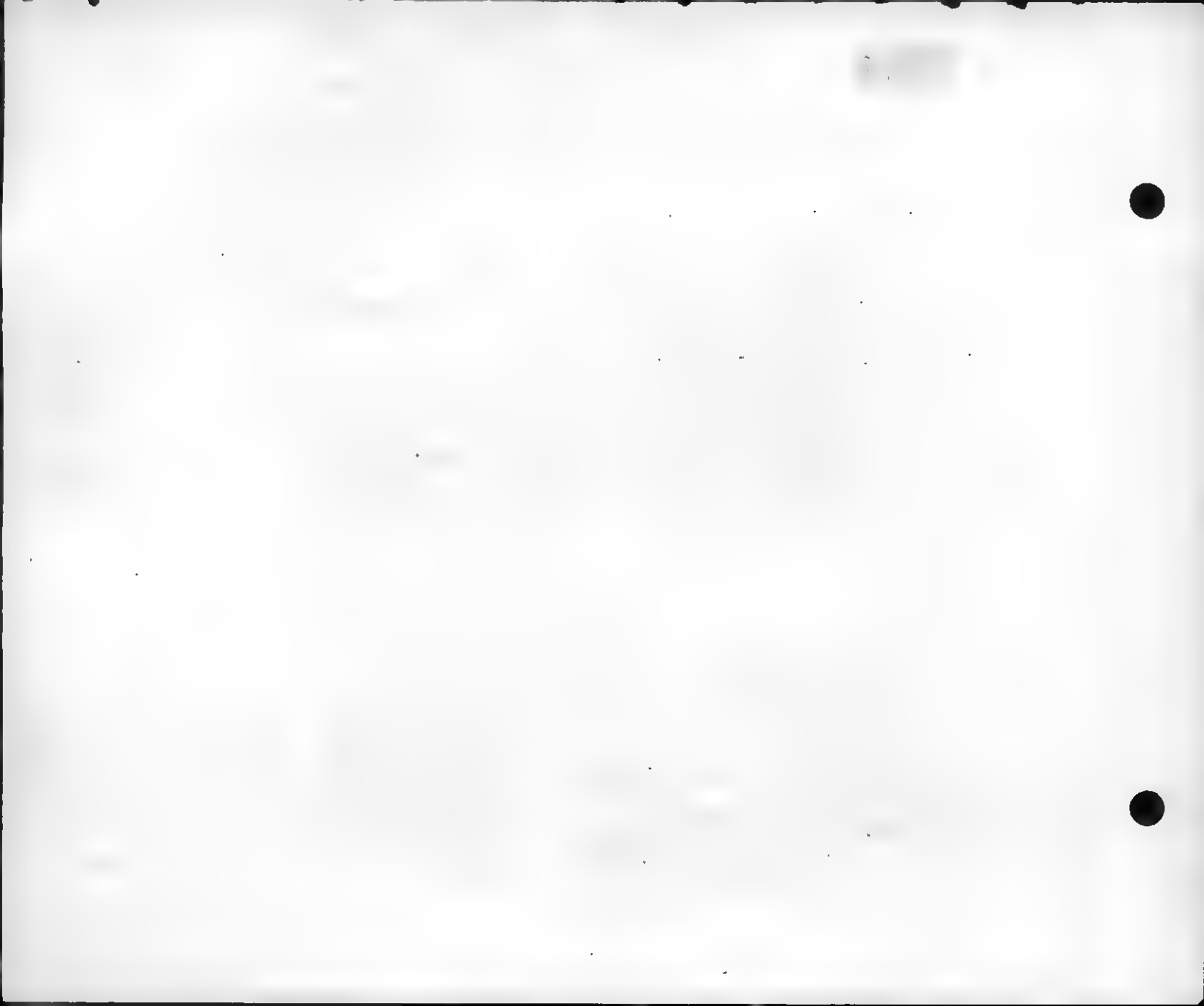
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the dual certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>-</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>District Heights</u> d. STREET ADDRESS <u>3815 74th Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Gabriele (NMI) Panetta</u>		4. DATE OF DEATH Month Day Year <u>December 25, 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 1, 1887</u>
9. AGE (in years last birthday) <u>80</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tile & Marble Setter</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Tile & Marble</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Bernard Panetta</u>	
14. MOTHER'S MAIDEN NAME <u>Elizabeth</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>579-09-3347A</u>		17. INFORMANT <u>Rocco A.-son</u> Address <u>Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> DUE TO (b) <u>Emphysema</u> DUE TO (c) <u>Syn</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 day</u> <u>5 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 day</u> <u>5 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>65</u> to <u>12-24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12-25</u> , 19 <u>67</u> , and that death occurred at <u>12:15 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>John J. Raedy, M.D.</u>		22b. DATE SIGNED <u>12-25-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John J. Raedy, M.D.</u>		22d. ADDRESS <u>2904 Nichols Ave S.E.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-28-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Colmar Manor, Md.</u>	
24. FUNERAL DIRECTOR <u>Lee Funeral Home-300 4th St. NE Wash., D.C.</u>		25a. REC'D BY REGISTRAR <u>DEC 28 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>0 12-0-67</u>			



554

Consigned to the Rev. M. V. Vignoli, M.D. Examin. M.D.

Page 4 may be retained by the hospital or attending physician.

Page 4 may be retained by the hospital or attending physician.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

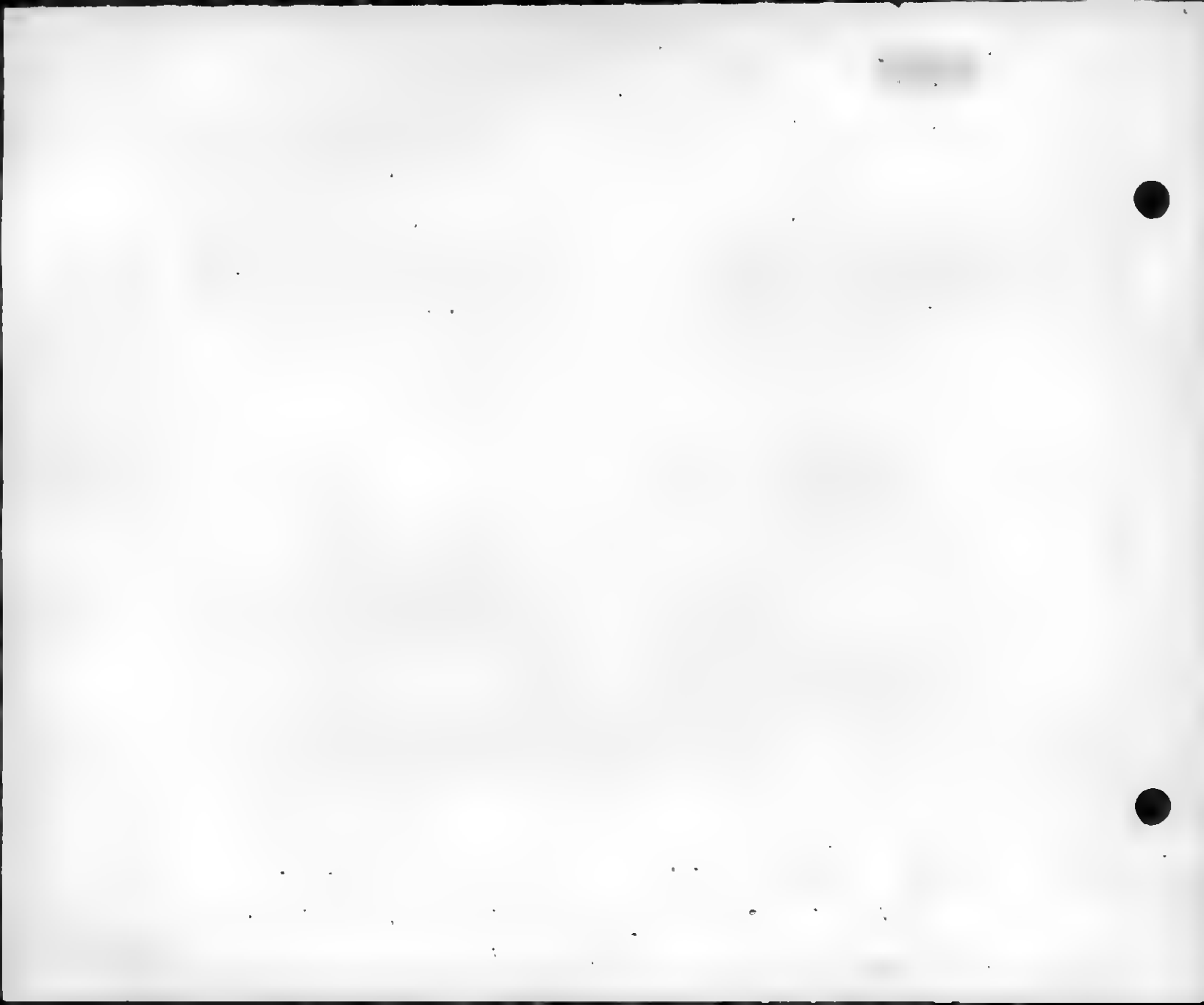
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17558

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly DOA		c. LENGTH OF STAY IN 15 DOA		2. USUAL RESIDENCE (When deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bradbury Heights		d. STREET ADDRESS 4415 Armand Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Adrian Pelletier		4. DATE OF DEATH Month Day Year December 30 19 67		5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 3, 1929		9. AGE (In years last birthday) 38 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Belanger, Quebec, Canada		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Cyrel Pelletier		14. MOTHER'S MAIDEN NAME Julia marie		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO (b) Arteriosclerotic heart disease DUE TO (c) unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH minutes		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 12-31-67	
ACTUAL SIGNATURE John Kehoe, M.D.		EXAMINER'S NAME (Type) John Kehoe, M.D.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 3, 1968	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION (City, town or county) (State) Arlington, Va.		24. FUNERAL DIRECTOR Murphy Funeral Home, Arlington, Virginia		25a. REC'D BY REGISTRAR JAN 4 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge		25c. ADDRESS		25d. ADDRESS	



1
6
4

555

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

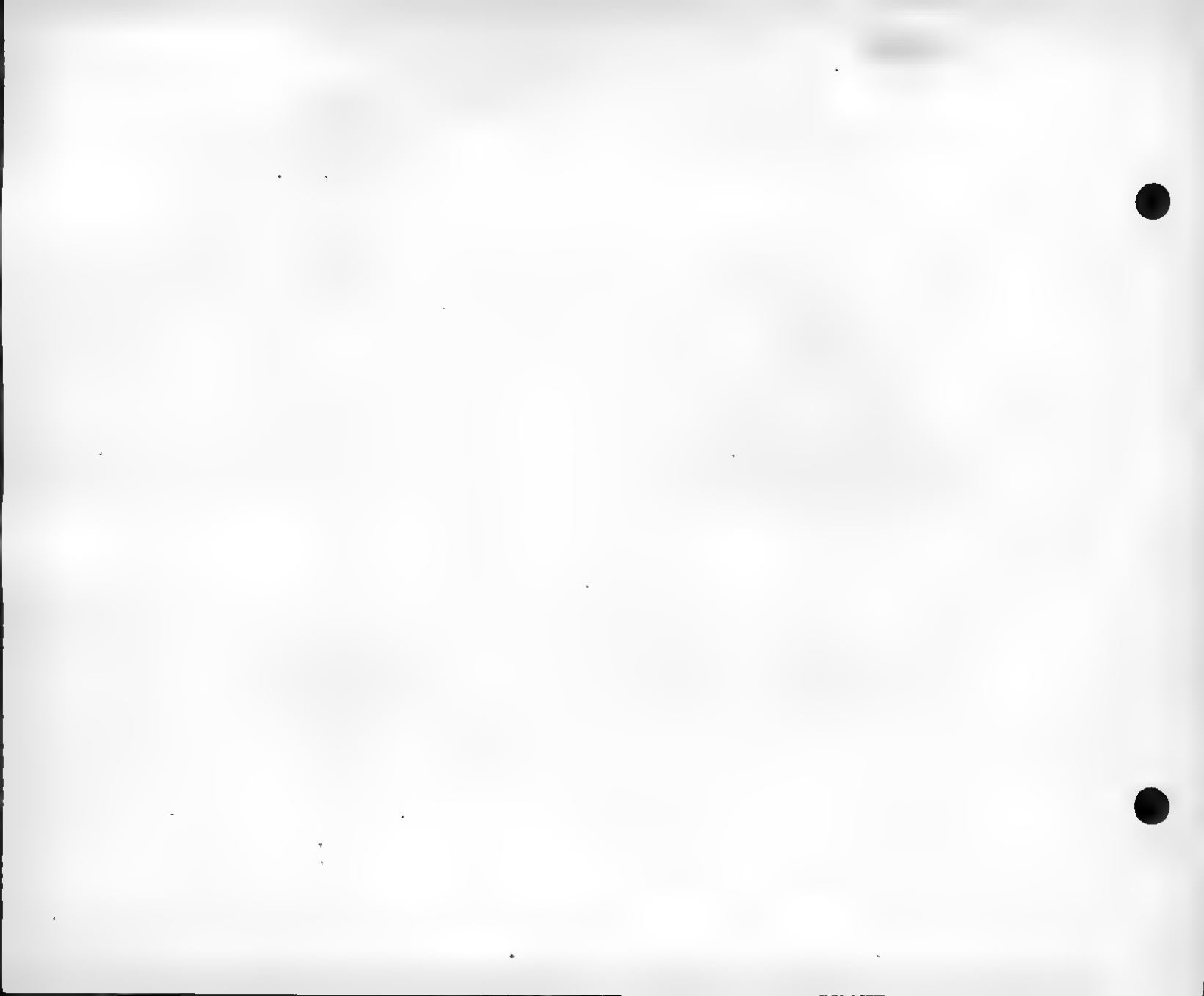
CERTIFICATE OF DEATH

17559

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Pro Geo	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4510 Yates Road		d. STREET ADDRESS 4510 Yates Road	
3 NAME OF DECEASED (Type or print) George Spencer Phillips		4 DATE OF DEATH Month Dec Day 20 Year 1967	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Nov 9, 1879
9 AGE (In years birthday) yrs. 88		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Justice of Peace	
10b. KIND OF BUSINESS OR INDUSTRY Retired		11 BIRTHPLACE (County & State or foreign country) Tennessee	
12 CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME George P Phillips	
14. MOTHER'S MAIDEN NAME Cecelia Spencer		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes Spanish American	
16. SOCIAL SECURITY NO.		17. INFORMANT Robert J Phillips	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. 443x IMMEDIATE CAUSE (a) CVA. DUE TO (b) Hypertensive Heart disease DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH hours years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12-20 , 19 67 , to 12-20 , 19 67 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 4:30 AM , from causes on and on the date stated above.			
22a. SIGNATURE Burton A. Johnson M.D.		22b. DATE SIGNED 12-21-67	
22c. PHYSICIAN'S NAME (Type) Burton A. Johnson		22d. ADDRESS Greenbelt Prof Bldg.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF Dec 22, 1967	23c. NAME OF CEMETERY OR CREMATOR Aminondale christian Bros	23d. LOCATION (City or Town) (County) (State) Aminondale Pro Geo Md.
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE DEC 27 1967	
		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

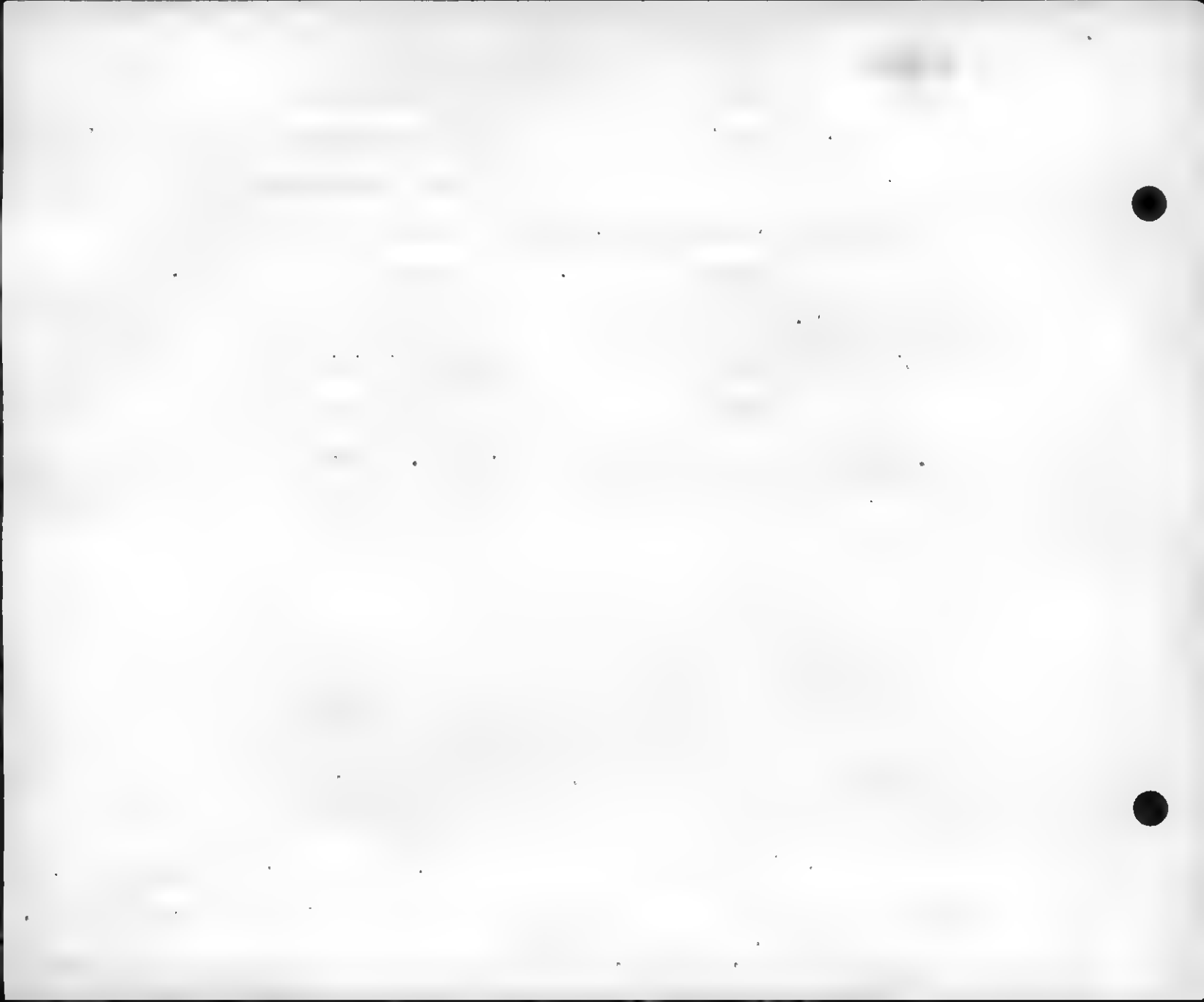
CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 5 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 5602 28th Parkway			
3 NAME OF DECEASED (Type or print) First Floyd Middle E. Last Pollock				4 DATE OF DEATH Month Dec. Day 31 Year 1967			
5 SEX Male	6. COLOR OR RACE Cauc.	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-27-79	9. AGE (in years last birthday) 88 yrs.	10. UNDER 1 YEAR Months 11 Days 1 Hours 1 Min.		11. UNDER 24 HRS Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Cabinet Maker			10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Richard D. Pollock			14. MOTHER'S MAIDEN NAME Unknown Mary E Daniels				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.			16. SOCIAL SECURITY NO.		17. INFORMANT Carlton E. Pollock Address Same AS # 2		
18 CAUSE OF DEATH (Enter on y one cause per line, for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) memorized with Pulmonary fracture DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) obscure DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) as seen from heart disease. Right bundle branch block						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 67		20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 12-26 , 19 67 , to 12-31 , 19 67 , that (I) (we) last saw the deceased alive on 12-31 19 67 , and that death occurred at 10:10P from causes and on the date stated above.							
22a. SIGNATURE Dr. Till Bergemann			22b. DATE SIGNED 1/2/68			22c. PHYSICIAN'S NAME (Type) Dr. Till Bergemann	
22d. ADDRESS Prof. Bldg., Centerway, Greenbelt, Md.			22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/2/68		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City or Town) (County) (State) Suitland Prince Georges Md.	
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road, Suitland, Maryland				25a. REC'D BY REGISTRAR DATE JAN 8 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

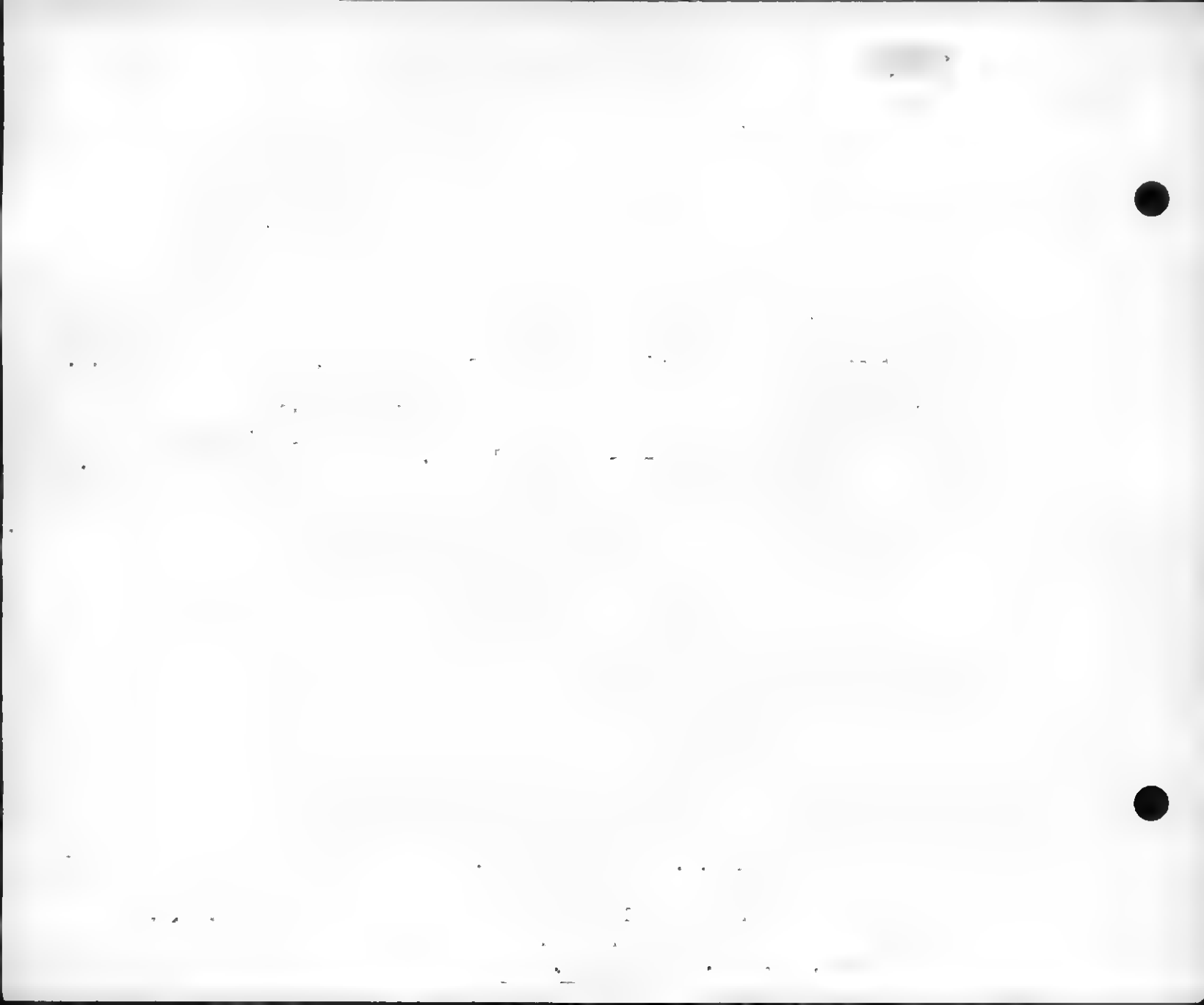
VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1756

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. STREET ADDRESS 6906 George Palmer Highway	
3 NAME OF DECEASED (Type or print) First Hazel Middle Virginia Last Ports		4. DATE OF DEATH Month 12 Day 1 Year 19 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH April 7 1893
9 AGE (In years last birthday) 74 yrs		10a USUAL OCCUPATION (Give kind of work done during most of work on 1b, even if retired) Seamstress	
10b KIND OF BUSINESS OR INDUSTRY American Wholesalers		11 BIRTHPLACE (State or foreign country) Washington, D.C.	
12 C. T. ZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME Frank Naylor	
14. MOTHER'S MAIDEN NAME Laura V. Crowley		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16 SOCIAL SECURITY NO 577-09-8541A		17 INFORMANT William L. Ports Jr	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Hypertensive cardio vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH minutes over 7 yrs.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D. EXAMINER'S NAME (Type)		22. DATE SIGNED 12-2-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 12/6/1967	
23c NAME OF CEMETERY OR CREMATORY Glenwood		23d LOCATION (City or Town) (County) (State) Washington, D.C.	
24 FUNERAL DIRECTOR W.W. Chambers, Co. Inc.		25a REC'D BY REGISTRAR DEC 7 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17558

CERTIFICATE OF DEATH

17562

1 PLACE OF DEATH a. COUNTY Prince George MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Suitland			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Washington, D.C.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suitland Nursing Home				d. STREET ADDRESS 3960 Second St. S.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Katharine Price Middle Last Price				4. DATE OF DEATH Month Dec Day 22 Year 1967			
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Aug. 5, 1888		9 AGE (in years last birthday) 79 yrs	10 IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State or foreign country) Washington, D.C.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Thomas Mason				14. MOTHER'S MAIDEN NAME Margaret Horrigan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Wash. D.C. NW Ernest V. Price 5624 MacArthur Blvd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Central Venous Occlusion DUE TO General Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 2 days 20 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 14, 1967 to Dec 22, 1967 , that (I) was lost saw the deceased alive on 12/14/67 19 67 , and that death occurred at 2:30 A.M. from causes on and on the date stated above.							
22a. SIGNATURE Ernest V. Price M.D.				22b. DATE SIGNED 12/22/67		22c. PHYSICIAN'S NAME (Type) E. V. Price M.D.	
22d. ADDRESS 20 Miss. Ave S.E.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-23-1967		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Md.	
24 FUNERAL DIRECTOR Lee Funeral Home 300 4th St. NE Wash. D.C.				25a. REC'D BY REGISTRAR DATE DEC 27 1967		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 11 & 12 Film 3346 1/2/68 kk

CERTIFICATE OF DEATH

11563

1 PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 5 1/2 hours d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brandywine d. STREET ADDRESS Rt. 1, Box 288 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Catherine D. Proctor		4 DATE OF DEATH Month December Day 13 Year 1967	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-4-95 9. AGE (in years last birthday) 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11 BIRTHPLACE (County & State, or foreign country) Pr. George's County, Md	
13. FATHER'S NAME Henry Harley		14. MOTHER'S MAIDEN NAME Harriett Proctor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Catherine Shariel		Address same	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Pulmonary Edema - Myocardial Infarction (c) Severe Atherosclerotic Heart Disease			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12/13 , 19 67 , to 12/13 , 19 67 , that (I) (we) last saw the deceased alive on 12/13 , 19 67 , and that death occurred at 4:30 P.M. , from causes and on the date stated above.			
22a SIGNATURE T. J. Hernandez		22b DATE SIGNED P.M.	
22c PHYSICIAN'S NAME (Type) T. J. HERNANDEZ MD		22d ADDRESS PRINCE GEORGE'S HOSPITAL	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or town) (County) (State)
Burial	Dec. 18, 1967	St Peter's Ch. Cem.	Waldorf, Chas. Co. Md.
24 FUNERAL DIRECTOR Martell Adams		25a RECD BY REGISTRAR Aguiasco MD	
25b REGISTRAR'S SIGNATURE William Judge		DATE DEC 21 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



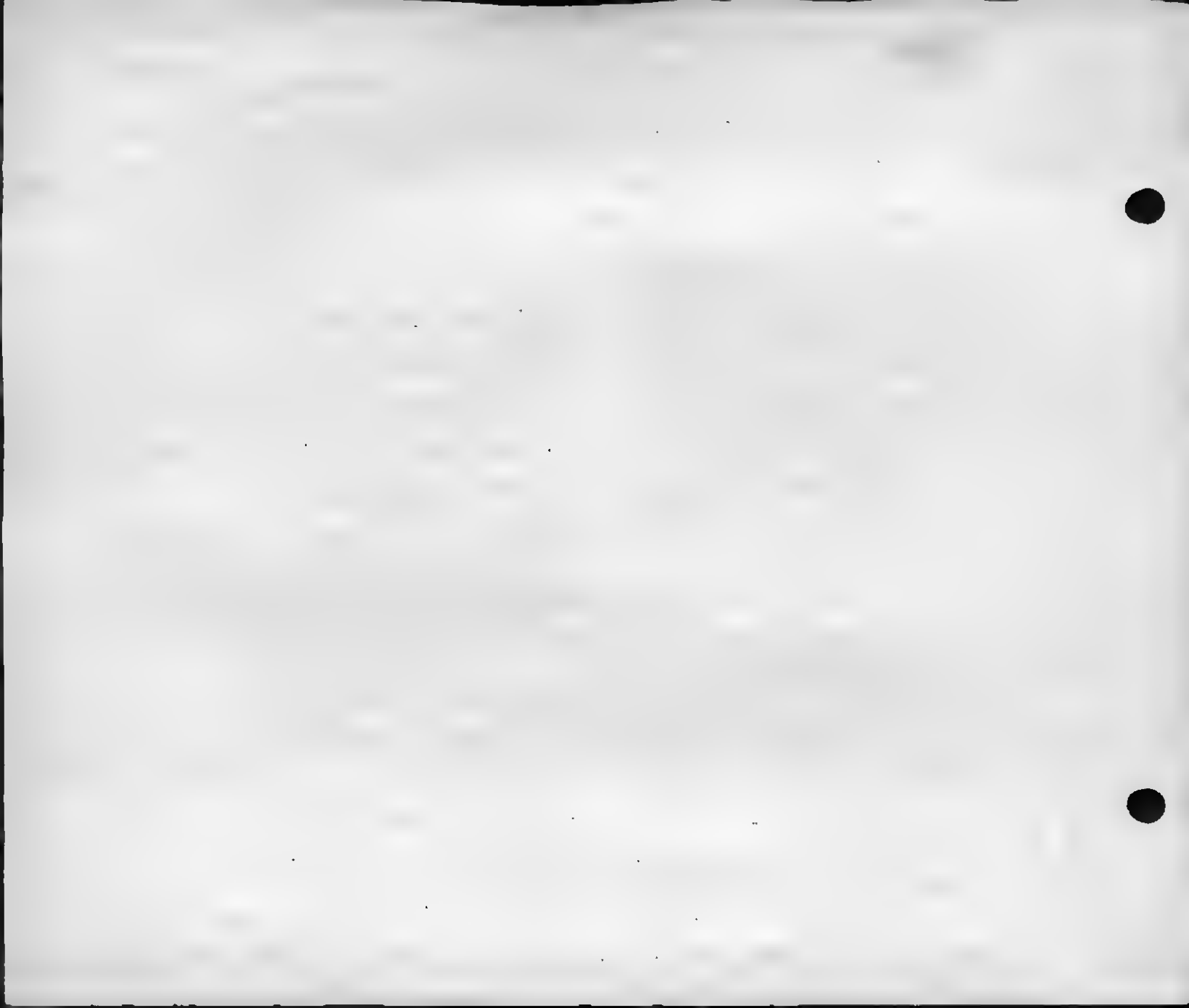
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham</u> LENGTH OF STAY IN 1b c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Lanham General Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Mont</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burtonville</u> d. STREET ADDRESS <u>3929 Sandy Spring Rd</u>					
3. NAME OF DECEASED (Type or print) <u>THOMAS F. REED</u>				4. DATE OF DEATH Month <u>12</u> - Day <u>9</u> - Year <u>1967</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 2, 1904</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Father</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>construction</u>					
13. FATHER'S NAME <u>Thomas Reed</u>				14. MOTHER'S MAIDEN NAME <u>Grace W. Wheelbarger</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Laurie Kell - Abner</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)								INTERVAL BETWEEN ONSET AND DEATH <u>20 min</u> <u>20 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> <u>1955</u> to <u>12/9, 1967</u> that (I) (we) last saw the deceased alive on <u>12/9, 1967</u> and that death occurred at <u>9:10 AM</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Frank Weaver, Jr., M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>FRANK WEAVER JR</u>				22d. ADDRESS <u>LAUREL, MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
<u>Burial</u>		<u>12-12-67</u>		<u>F-T Rinalden Cem</u>		<u>Calmar Manor Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Donohue, Laurel, Md</u>				25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>DEC 18 1967</u> <u>J. Charles Judge</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

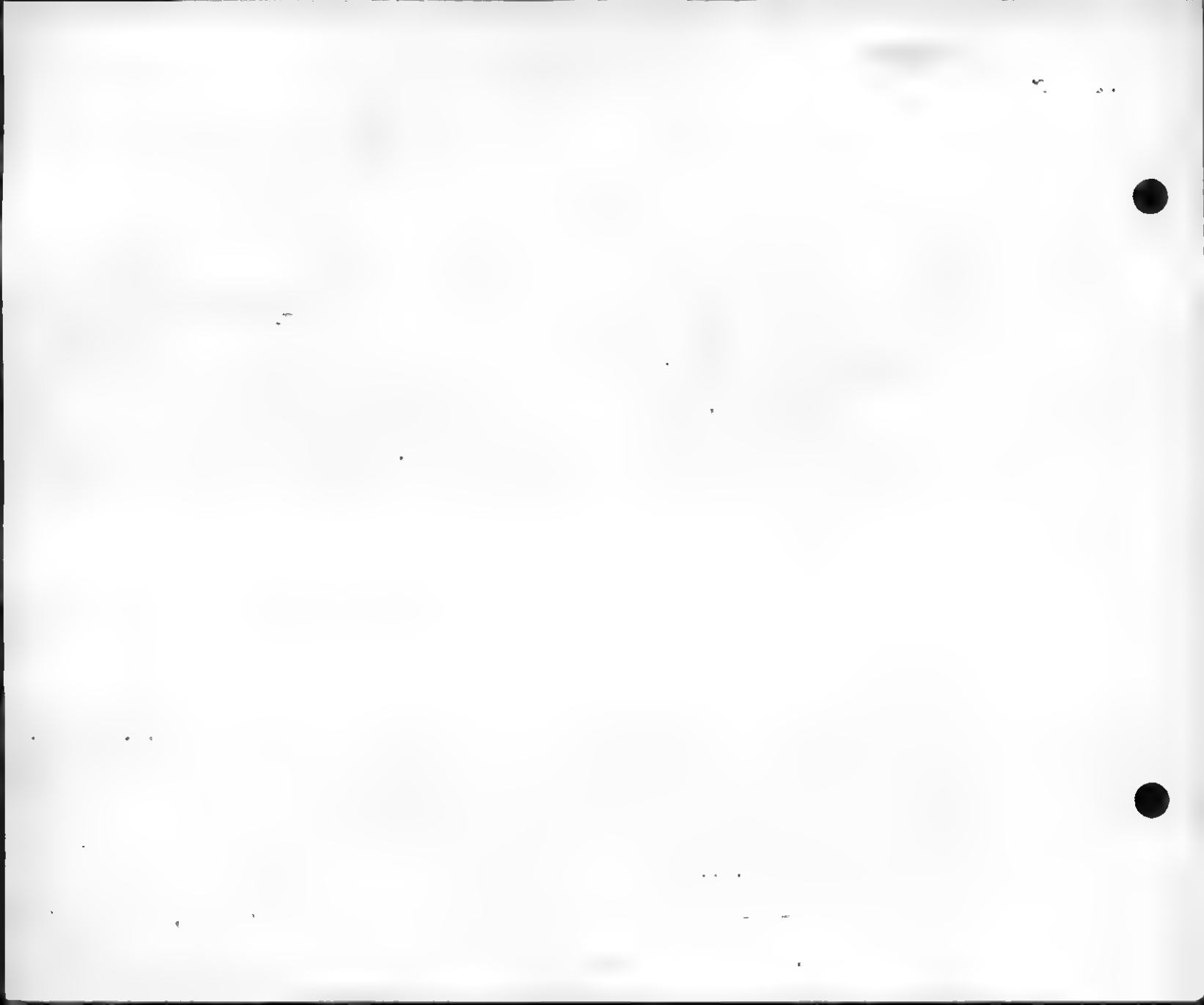
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

77561

1565

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs DOA c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Andrews Air Force Base Hospital				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf d. STREET ADDRESS Route 3, Box 513 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last Joan Yvonne Riecke			4 DATE OF DEATH Month Day Year 12 15 19 67				
5 SEX female	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9-1-40	9 AGE (In years last birthday) 27	10 IF UNDER 1 YEAR Months Days Hours Min		
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk - Sears Roebuck Co		10b KIND OF BUSINESS OR INDUSTRY INDUSTRY		11 BIRTHPLACE (State or foreign country) Mississippi			
13 FATHER'S NAME Robert H. Fox			14. MOTHER'S MAIDEN NAME Lavada Williams				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 427 68 3908		17 INFORMANT Conrad C. Riecke Same as Item #2			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of brain 816.6 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH minutes		
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19 WAS A TOLPS PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 8) driver of car involved in collision					
20c TIME OF INJURY Month, Day, Year Hour a.m. m. 10:30pm 12-15 1967		20d INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> hot while <input checked="" type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) Route 5	20f (City or town) TB	(County) P.G.		
(State) Md.							
21. I certify that I took charge of the remains described above and an Autopsy <input type="checkbox"/> Inspect an <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 12-17-67			
23a BURIAL, CREMATION, OR REMOVAL (Specify) Burial		23b DATE THEREOF 12-20-1967		23c NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery			
23d LOCATION (City or Town) Water Valley, Mississippi		23e (County) P.G.		23f (State) Md.			
24 GENERAL DIRECTOR'S SIGNATURE Simmons Bros.		ADDRESS Wash DC		25a REC'D BY REGISTRAR DEC 19 1967			
25b REGISTRAR'S SIGNATURE Charles Judge							

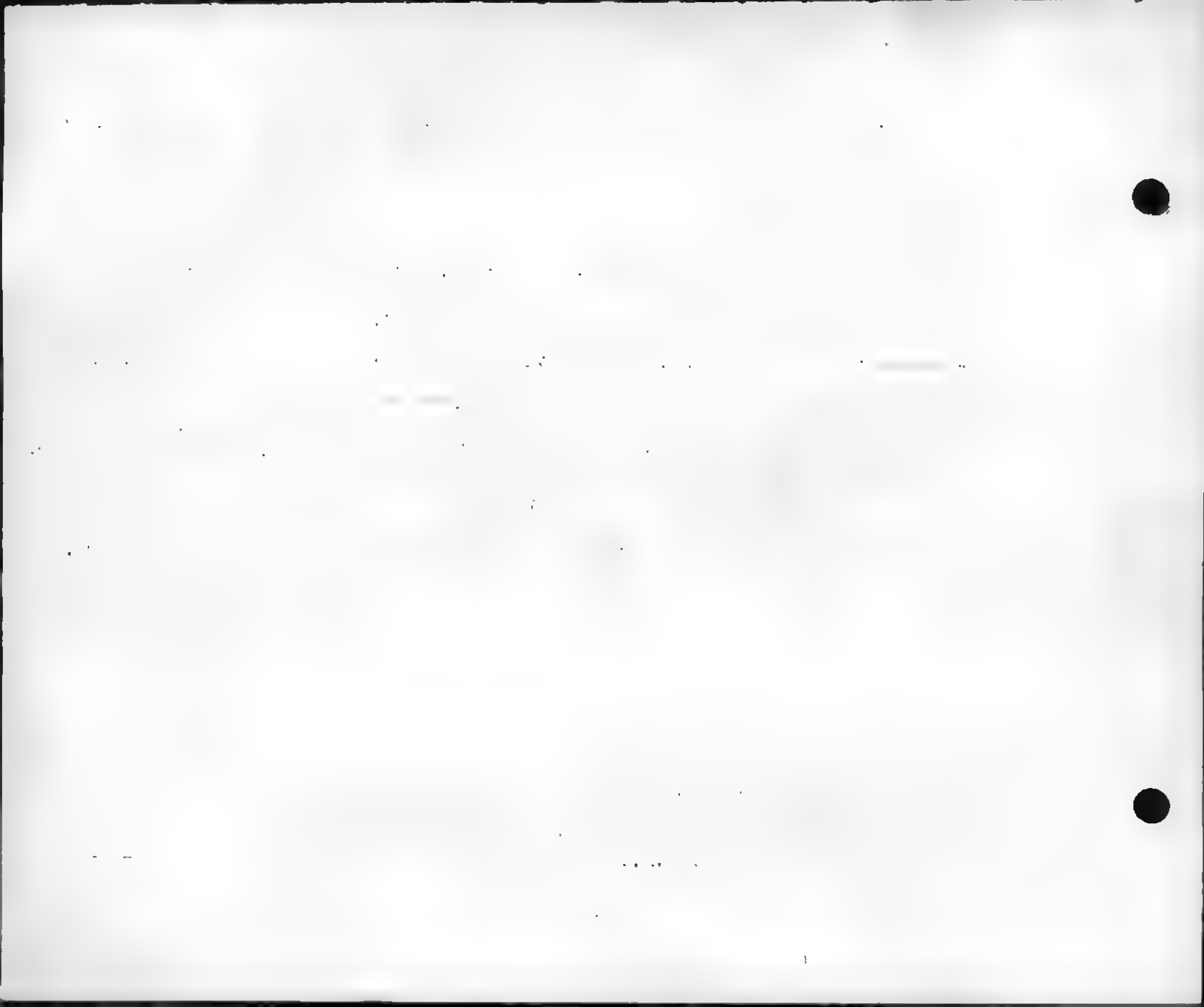


FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div>7362</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>Item 7 Bill G396</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>17566</div>										
1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park d. STREET ADDRESS 9005 48th Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Everett Milvern Roberts, Sr.			4. DATE OF DEATH December 23 19 67		5. SEX male			6. COLOR OR RACE white		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH February 16, 1898 69 yrs.		9. AGE (In years last birthday) 69 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		11. BIRTHPLACE (State or foreign country) Maryland	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist			10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Albert Roberts					14. MOTHER'S MAIDEN NAME Alverda Ortlip					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO. none		17. INFORMANT Everett M. Roberts Jr. College Park, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 7200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH Minutes 8 yrs.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale.			22. DATE SIGNED 12-23-67		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 12/26/67		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City, town or county) (State) Colmar Manor P.G. Md.			
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md					25a. REC'D BY REGISTRAR DEC 29 1967		25b. REGISTRAR'S SIGNATURE [Signature]			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

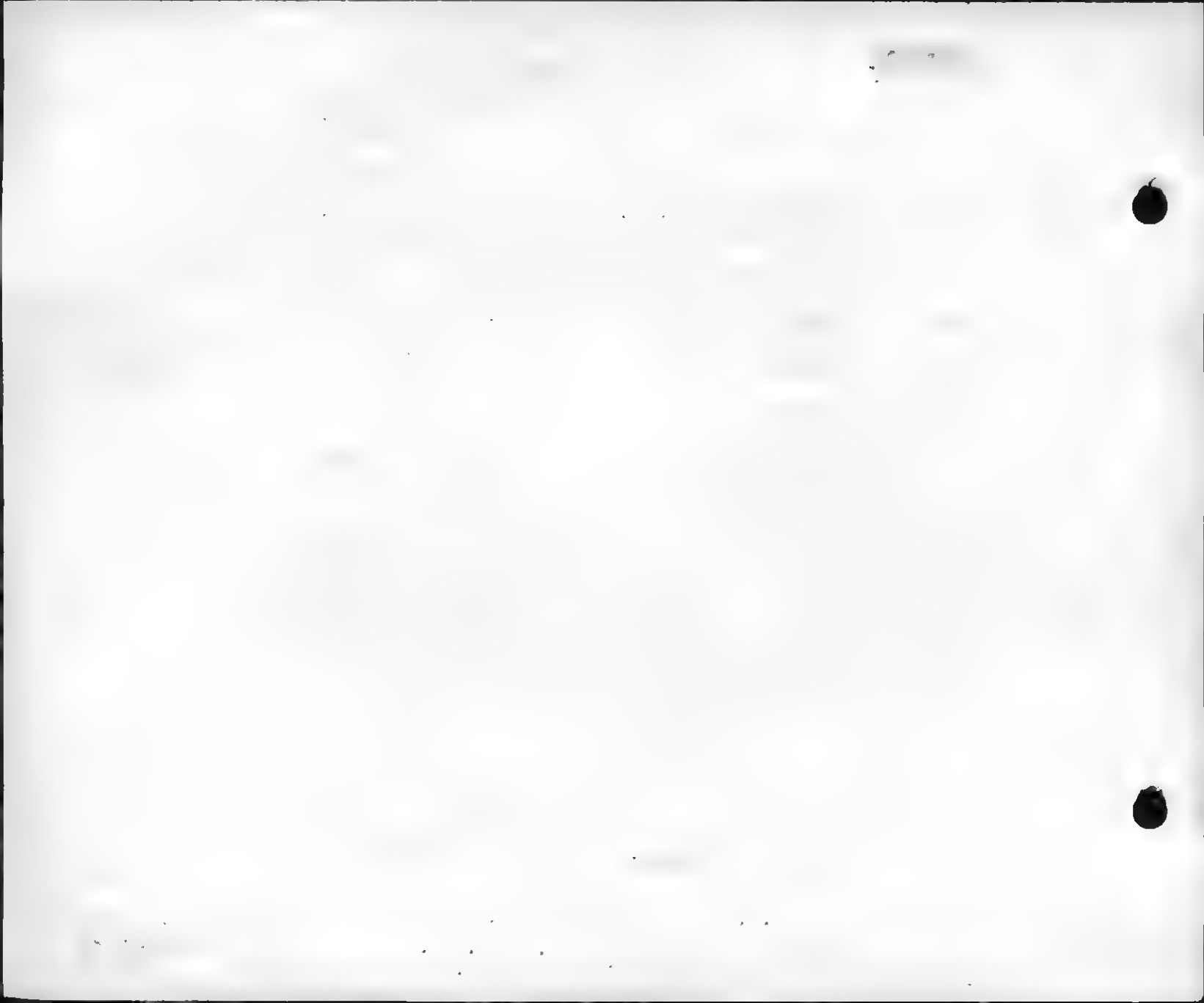
CERTIFICATE OF DEATH

7563

11567

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Alexandria			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews AFB				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Malcolm Grow USAF Hospital				d. STREET ADDRESS 5834 Edgehill Dr			
3. NAME OF DECEASED (Type or print) First Middle Last ROBERT LAWRENCE ROBERTS				4. DATE OF DEATH Month Day Year December 28 1967			
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 Apr 32		9. AGE (in years last birthday) 35 yrs	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Airman			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Rutherford Roberts				14. MOTHER'S MAIDEN NAME Harriet Cobb			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 1950-1965			16. SOCIAL SECURITY NO 226-36-2793		17. INFORMANT Wife Peggie Roberts Address Same as item #2		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SEPTICEMIA 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) INTESTINAL PERFORATION DUE TO (c) CARCINOMA OF THE STOMACH WITH METASTASES							INTERVAL BETWEEN ONSET AND DEATH 1 DAY 2 1/2 YEARS
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11 Dec, 1967 , to 28 Dec, 1967 , that (I) (we) last saw the deceased alive on 28 Dec 1967 , and that death occurred at 4:30 PM , from causes and on the date stated above.							
22a. SIGNATURE <i>Leonard R Farber</i>				22b. DATE SIGNED 28 Dec 67		22c. PHYSICIAN'S NAME (Type) LEONARD R FARBER	
22d. ADDRESS MALCOLM GROW USAFH ANDREWS AFB				22e. REGISTRAR'S SIGNATURE <i>J. Charles Jones</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 2, 1968		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) XXXXX Arlington, Virginia	
24. FUNERAL DIRECTOR <i>J. Cunningham</i> Cunningham Funeral Home, Inc. Alex., Va. Cameron & Alfred Sts.				25a. REC'D BY REGISTRAR JAN 3 1968		25b. REGISTRAR'S SIGNATURE <i>J. Charles Jones</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

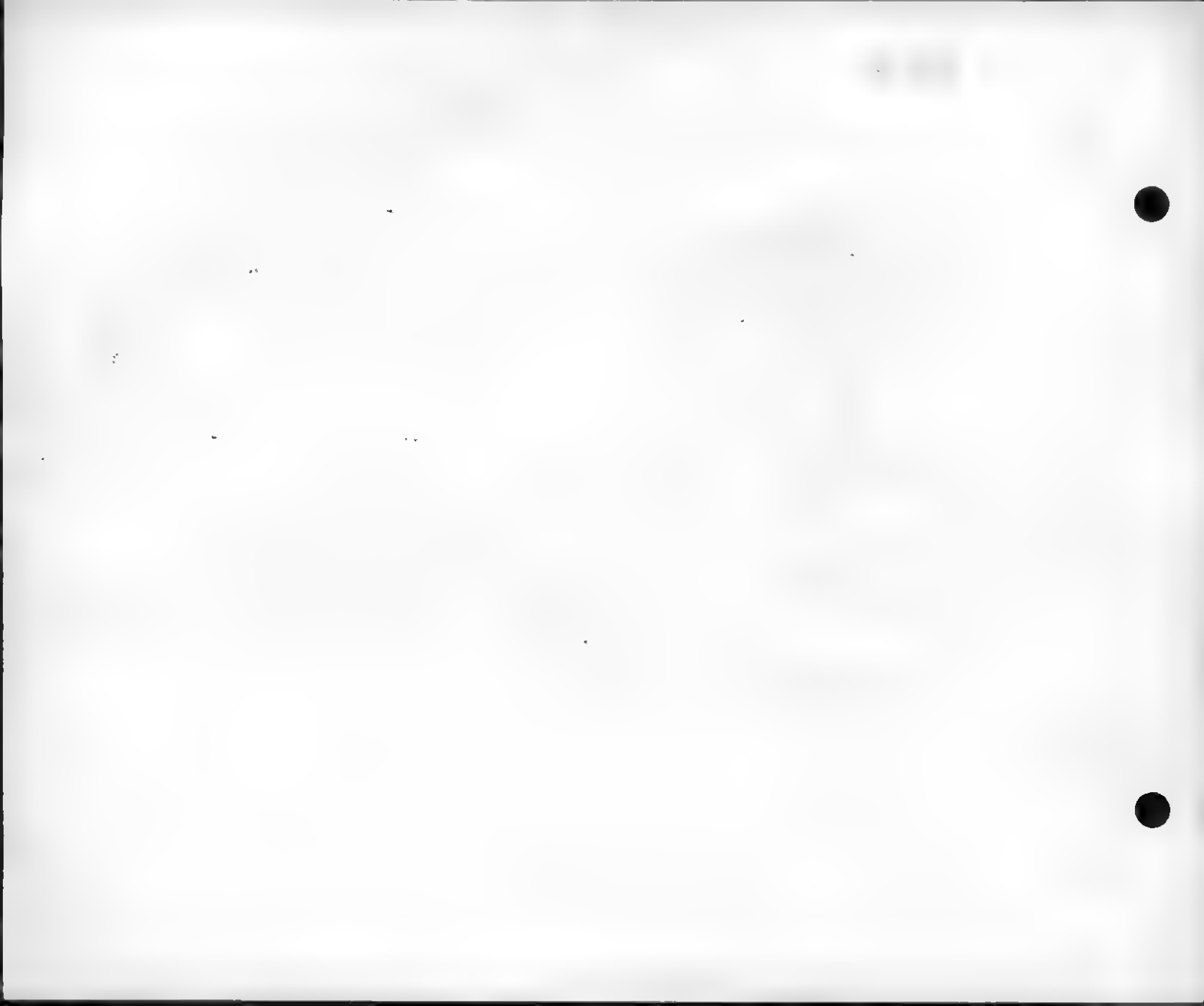
CERTIFICATE OF DEATH

15564

1568

1 PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LANHAM			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARYLAND PARK	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MAGNOLIA GARDENS NURSING HOME				d. STREET ADDRESS 6526 COOLIDGE ST		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last ANNIE BARBARA ROBERTSON				4 DATE OF DEATH Month Day Year DEC 25 19 67			
5 SEX FEMALE		6 COLOR OR RACE CAUCASIAN		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT 22, 1884	
9 AGE (In years last birthday) 83 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) MARYLAND	
12 CITIZEN OF WHAT COUNTRY? U.S.				13 FATHER'S NAME GOTTLIEB SCHNEIDER			
14. MOTHER'S MAIDEN NAME CHRISTINE WENZEL				15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			
16. SOCIAL SECURITY NO. 216-40-6682A				17. INFORMANT MRS MYRTLE MARTIN Address SAME AS #2			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 wk 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DIABETES MELLITUS						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June, 1967 to 12/25, 1967 , that (I) (we) last saw the deceased alive on 12/25 1967 , and that death occurred at 2:45 A , from causes and on the date stated above.							
22a. SIGNATURE <i>[Signature]</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/25/67	
22c. PHYSICIAN'S NAME (Type) NORMAN D. COMEAU				22d. ADDRESS 3503 PENNY ST MT RAINIER MD			
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-28-1967		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM		23d. LOCATION (City or Town) (County) (State) COLMAR MANOR MARYLAND	
24 FUNERAL DIRECTOR W.W. CHAMBERS CO. RIVERDALE, MD				25a. REC'D BY REG STRAR DATE DEC 29 1967		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 only 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (D)
6M 1/67

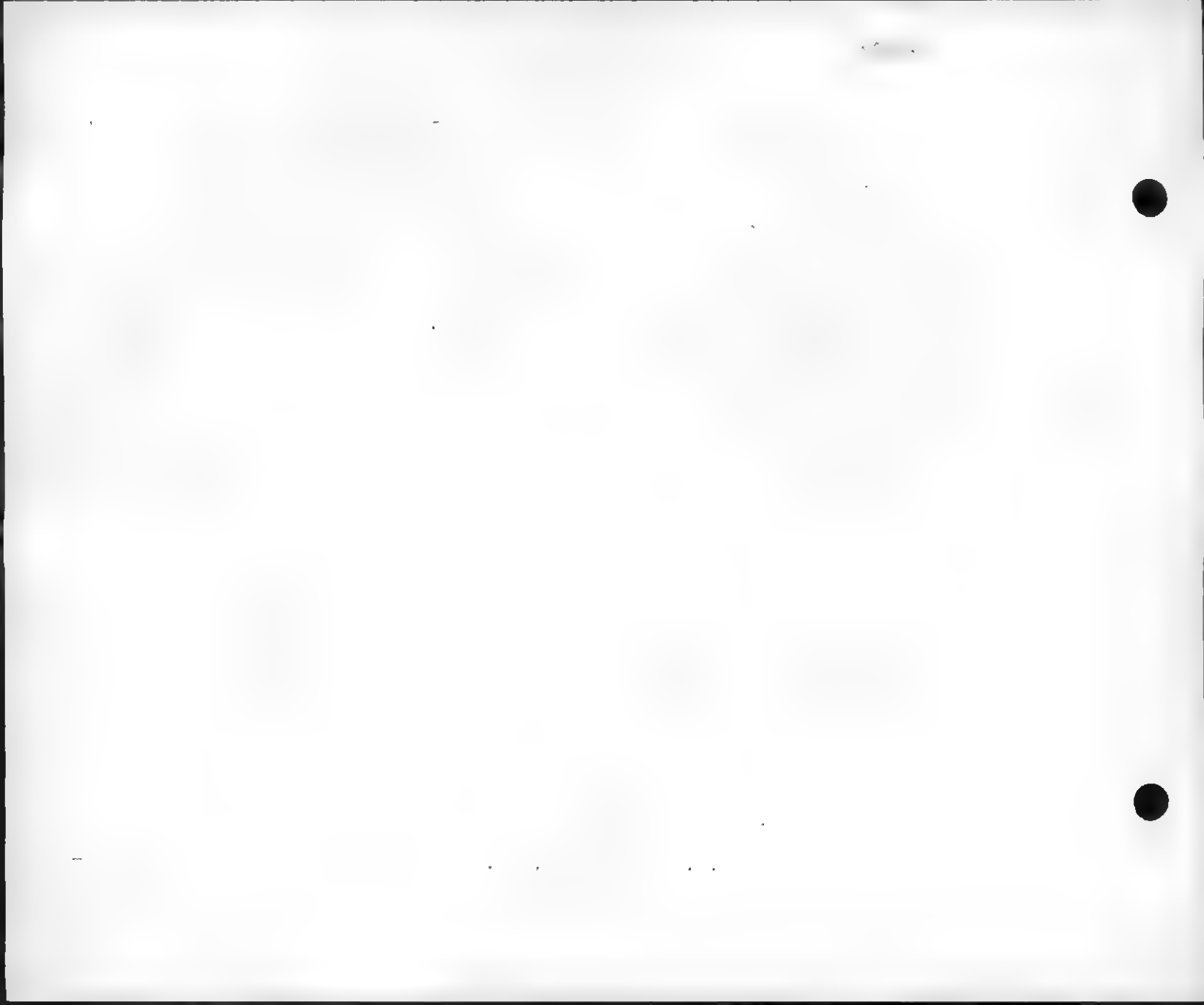
**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12565

17569

1 PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. LENGTH OF STAY IN 1b <u>DOA</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>				d. STREET ADDRESS <u>7308 Edmonston Road</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Leland Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Rodenhause</u> Last <u>Rodenhause</u>				4 DATE OF DEATH Month <u>12</u> Day <u>16</u> Year <u>1967</u>			
5 SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>17 Jan. 1895</u>	
9 AGE (in years last birthday) <u>72</u> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b KIND OF BUSINESS OR INDUSTRY <u>—</u>		11 BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>EUGENE BACH</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>HAROLD RODENHAUSEN</u>		Address <u>5209 MINEOLA RD COLLEGE PARK, MD</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>44</u> DUE TO <u>Hypertensive cardio vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>—</u> DUE TO (c) <u>—</u>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>over 15 yrs</u>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>		20d INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <u>12-17-67</u>		ACTUAL SIGNATURE <u>John Kehoe, M.D.</u> M.D. EXAMINER'S NAME (Type) <u>John Kehoe, M.D.</u> Riverdale, Md. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>12-19-67</u>		23c NAME OF CEMETERY OR CREMATORY <u>WASH. NAT. CEM</u>		23d LOCATION (City or Town) (County) (State) <u>SUITLAND, MD</u>	
24 FUNERAL DIRECTOR <u>W.W. CHAMBERS, Co RIVERDALE, MD</u>		25a REC'D BY REGISTRAR <u>DEC 21 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c REGISTRAR'S NAME	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham</u>		c LENGTH OF STAY IN 1b <u>8 Months</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Magnolia Gardens Nursing Home</u>		d STREET ADDRESS <u>3923 Oliver Street</u>	
3 NAME OF DECEASED (Type or print) <u>Myrtle</u> First <u>J.</u> Middle <u>Rosen</u> Last		4. DATE OF DEATH Month <u>Dec.</u> Day <u>24</u> , Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 4, 1899</u>
9 AGE (In years last birthday) <u>68</u> yrs		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>19</u> Min <u>67</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Clerical</u>		10b KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13 FATHER'S NAME <u>John Randolph Jones</u>		14. MOTHER'S MAIDEN NAME <u>Hannie B. Doleman</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16 SOCIAL SECURITY NO. <u>216 44 9547</u>	
17. INFORMANT <u>Eugene F. Rosen</u> Same as #2 (husband)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <u>Cerebral thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>General atherosclerosis</u> (b) DUE TO <u>9 AM</u> (c) <u>9 PM</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 1967</u> to <u>Dec 24</u> , 1967, that (I) (we) last saw the deceased alive on <u>Dec 16</u> , 1967, and that death occurred at <u>7 PM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>L. W. MALIN M.D.</u>		22b. DATE SIGNED <u>Dec 24, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. W. MALIN M.D.</u>		22d. ADDRESS <u>Rockville, Md.</u>	
23a BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>12/28/67</u>	
23c NAME OF CEMETERY OR REMOVAL <u>Providence Meth. Church</u>		23d LOCATION (City or Town) (County) (State) <u>Chiltons Va.</u>	
24 FUNERAL DIRECTOR <u>F. Gasch's Sons, Hyattsville, Md.</u>		25a REC'D BY REGISTRAR DATE <u>JAN 2 1968</u>	
25b REGISTRAR'S SIGNATURE <u>[Signature]</u>			



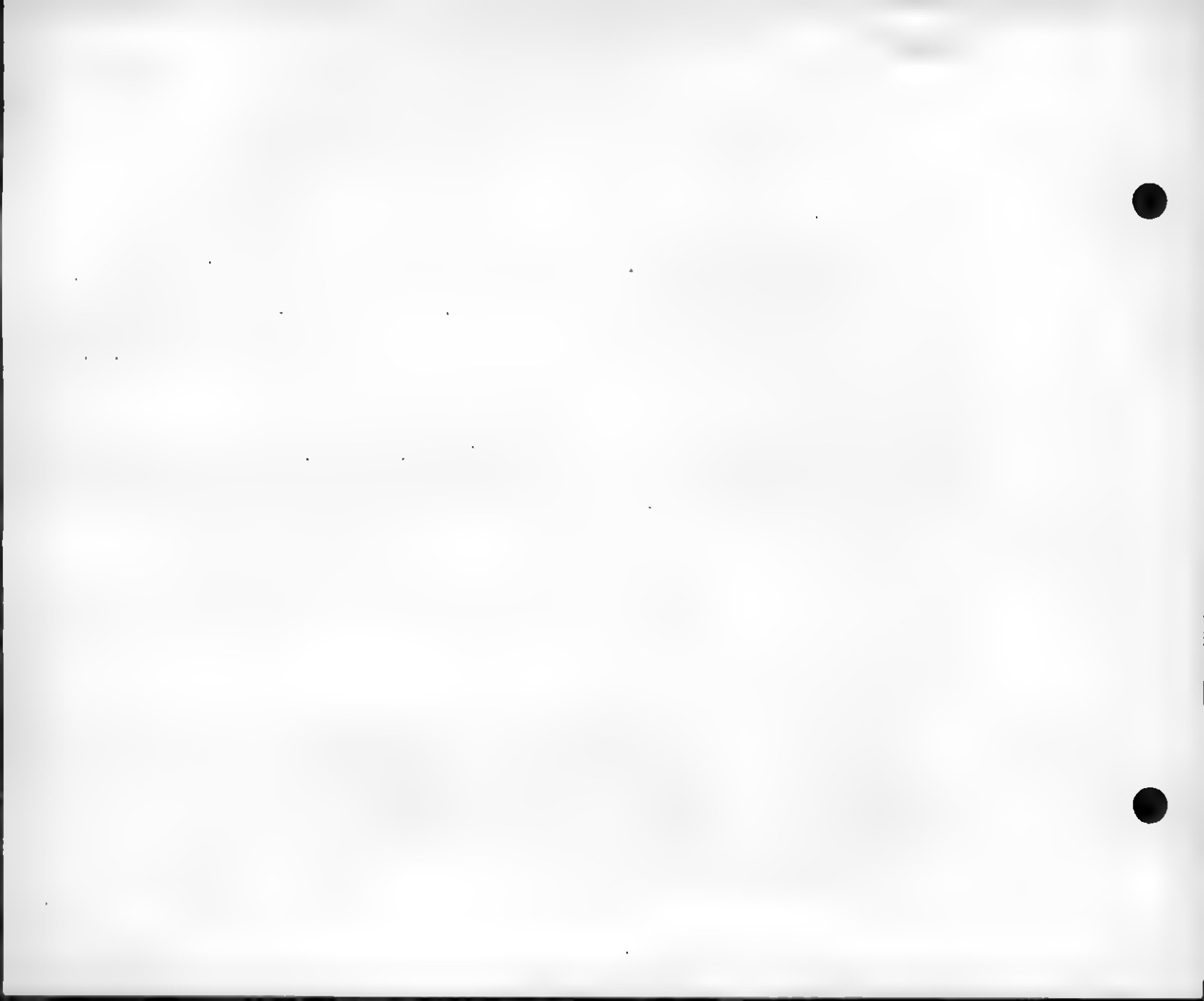
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg c. LENGTH OF STAY IN 1b 1		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg Apt 504	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6011 Emerson Street		d. STREET ADDRESS 6011 Emerson Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lucille Middle A. Last Russell		4. DATE OF DEATH Month Dec. Day 26 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1918
9. AGE (In years last birthday) 49 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (County & state, or foreign country) Georgia
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Waters	
14. MOTHER'S MAIDEN NAME Agatha Wotta		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. no		17. INFORMANT William C. Russell Same as #2 (husband)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Eckhausen DUE TO 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Lung & 1 year (c) Generalized Carcinoma INTERVAL BETWEEN ONSET AND DEATH 1 week			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 9. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12-24, 1967 to 12-26, 1967 that (I) (we) last saw the deceased alive on 12-24, 1967 and that death occurred at 1:50 PM , from causes and on the date stated above.			
22a. SIGNATURE Dayton O Watkins		22b. DATE SIGNED 12-27-67	
22c. PHYSICIAN'S NAME (Type) DAYTON O WATKINS		22d. ADDRESS 3318 Annapolis Rd Bladensburg Md	
23a. BURIAL, CREMATION, or other disposition Entombment	23b. DATE THEREOF 12/29/67	23c. NAME OF CEMETERY OR CREMATORY Clinton Grove	23d. LOCATION (City or town) (County) (State) Malcombe Mich.
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Maryland		25a. REC'D BY REG STRAR DATE JAN 2 1968	
		25b. REGISTRAR'S SIGNATURE [Signature]	



MARYLAND STATE DEPARTMENT OF HEALTH

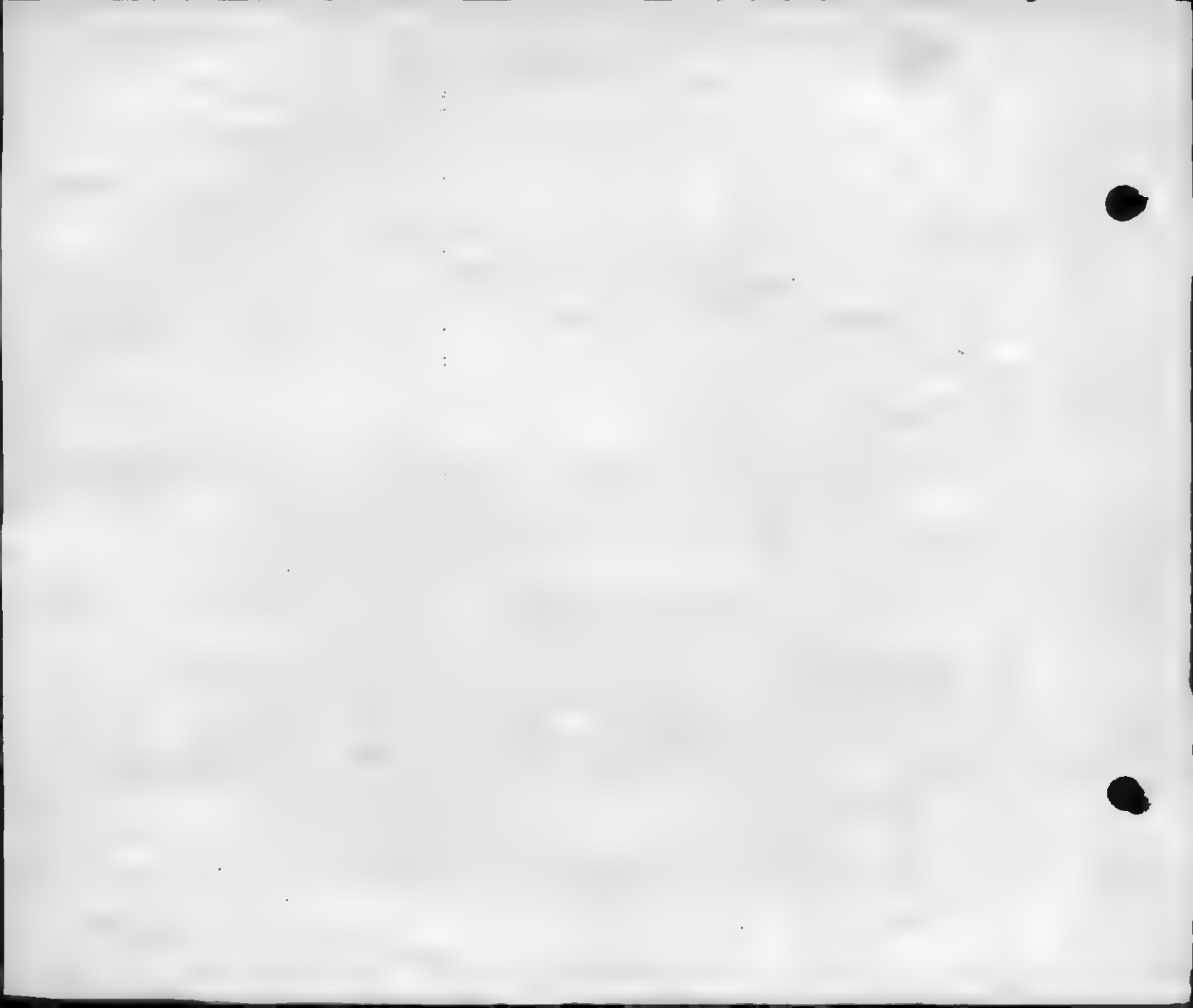
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1157.3

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Md.</u> c. LENGTH OF STAY IN 1b <u>12/15/67 - 12/21/67</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CORRELL MANOR, 4722 LaSalle Rd</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Washington, D.C.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> d. STREET ADDRESS <u>3800 New Hampshire Ave. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Francis de Sales</u> First Middle Last		4. DATE OF DEATH <u>12 21 1967</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 19, 1885</u> Yrs		9. AGE (In years last birthday) <u>82</u> yrs IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>GOVERNMENT EMPLOYEE</u> 11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON, D.C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>		13. FATHER'S NAME <u>Matthew Rabin</u> 14. MOTHER'S MAIDEN NAME <u>MARY ELIZABETH CULLIGHAN</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>217-52-5734</u> 17. INFORMANT <u>CARROLL MANOR RECORDS</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS C</u> (b) <u>MYOCARDIAL INFARCTION</u> (c) <u>2 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 1</u> <u>1967</u> to <u>Dec 21</u> <u>1967</u> that (I) (we) last saw the deceased alive on <u>Dec 21</u> <u>1967</u> and that death occurred at <u>3:30 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Thomas F. Collins</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>THOMAS F. COLLINS</u>		22d. ADDRESS <u>322- H H N.E.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-23-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Collins</u>		ADDRESS <u>3821 14th St. N.W. Wash. D.C.</u>		25a. REC'D BY REGISTRAR <u>DEC 26 1967</u> 25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

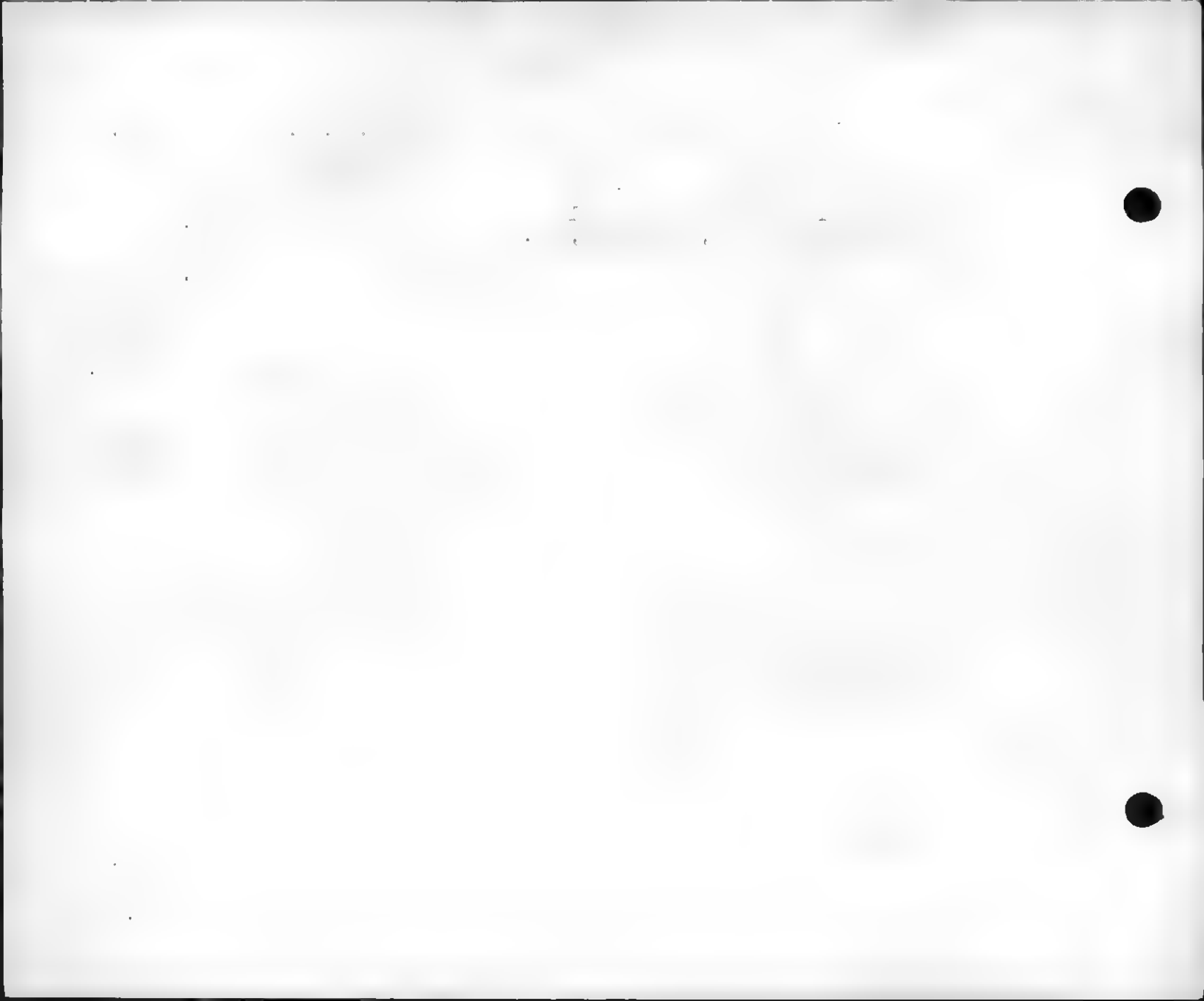
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Wash. D. C. b. COUNTY N. E.	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c LENGTH OF STAY in 1b 2 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital 1800 Queensbury Rd., Riverdale, Md.		d STREET ADDRESS 4024 20th Street N.E.	
3 NAME OF DECEASED (Type or print) Thomas W. Sargent		4. DATE OF DEATH Month Dec. Day 23 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/6/99
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate		10b. KIND OF BUSINESS OR INDUSTRY Sell	
11 BIRTHPLACE (County & State, or foreign country) Dist. of Columbia		12 CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Theodore F. Sargent		14. MOTHER'S MAIDEN NAME Sara Whitley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv.)		16 SOCIAL SECURITY NO	
17. INFORMANT Virginia Sargent (sister)		Address Farrett Park Maryland	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO (b) ATRIAL AND VENTRICULAR FIBRILLATION DUE TO (c) 3 DAYS		INTERVAL BETWEEN ONSET AND DEATH 1 MONTH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a m p m 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12-20 , 19 67 , to 12 23 , 19 67 , that (I) (we) last saw the deceased alive on 12 22 , 19 67 , and that death occurred at 4:50 AM , from causes and on the date stated above			
22a SIGNATURE C. J. Houmann		22b DATE SIGNED 12-23 67	
22c PHYSICIAN'S NAME (Type) C. J. HOUMANN		22d ADDRESS RIVERDALE, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 12/27/67	23c NAME OF CEMETERY OR CREMATORY Rock Creek	23d LOCATION (City or Town) (County) (State) Washington D. C.
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Maryland		25a REC'D BY REGISTRAR DATE JAN 2 1968	
		25b. REGISTRAR'S SIGNATURE Wedge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12570
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 8 Form 2376 1/15/58 KK
12571
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Gre Geo</u>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Cherbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherbury, Ind.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Geo. Hosp.</u>				d. STREET ADDRESS <u>2327 Belvoir Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Ann</u> Middle <u>H.</u> Last <u>Sayan</u>				4. DATE OF DEATH Month <u>12</u> Day <u>30</u> Year <u>1967</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-9-913 94</u>	
9. AGE (In years last birthday) <u>73</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>syrie</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Sam</u>				14. MOTHER'S MAIDEN NAME <u>Mary Baran</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>Elie A. Sayan Cherbury, Ind.</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Pulmonary Embolism</u> (c) <u>Coronary Heart Failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>2 hours</u> <u>one year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>67</u> , to <u>12-30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12-30</u> 19 <u>67</u> , and that death occurred at <u>7:30</u> M, from causes and on the date stated above							
22a. SIGNATURE <u>Charles Sahakyan</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>12/30/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>CHARLES SAHAKYAN</u>				22d. ADDRESS <u>601 LANOVER RD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 3, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Wheaton Montgomery Md.</u>	
24. FUNERAL DIRECTOR <u>F. Gasch's Sons Hyattsville, Md.</u>				25a. REC'D BY REGISTRAR <u>JAN 8 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Pr. Geo's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u>		c. LENGTH OF STAY IN 1b <u>70 Days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greenbelt Convalescent Center</u>		d. STREET ADDRESS <u>7010 Greenbelt Rd</u>	
3 NAME OF DECEASED (Type or print) First <u>George C.</u> Middle <u>Schaefer</u> Last <u>Schaefer</u>		4 DATE OF DEATH Month <u>Dec</u> Day <u>19</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>JANUARY 26</u> 1896
9 AGE (In years last birthday) <u>71</u> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES - Manager</u>	
10b KIND OF BUSINESS OR INDUSTRY <u>Equipment Co.</u>		11 BIRTHPLACE (County & State, or foreign country) <u>N. Y.</u>	
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>George Schaefer</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Behrens</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Unknown</u>	
16. SOCIAL SECURITY NO <u>---</u>		17. INFORMANT <u>Mrs ELEANOR Nelson</u> Address <u>same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GRAM NEGATIVE SEPTICEMIA</u> DUE TO (b) <u>EPIDIDYMITIS</u> DUE TO (c) <u>CHRONIC PROSTATIC INFECTION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u> <u>3 MONTHS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>EMPHYSEMA SEVERE</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>OCT 10, 1967</u> to <u>DEC 19, 1967</u> , that (I) (we) last saw the deceased alive on <u>DEC 18, 1967</u> , and that death occurred at <u>9:42</u> M, from causes and on the date stated above.			
22a SIGNATURE <u>Norman K. Bohrer</u>		22b. DATE SIGNED <u>Dec. 19, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Norman K. Bohrer, M. D.</u>		22d. ADDRESS <u>3231 Superior Lane, Bowie, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/21/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Weehawken Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>North Bergen, N. J.</u>
24 FUNERAL DIRECTOR <u>Ritchie Bros. Fun'l Home - Upper Marlboro,</u>		25a. REC'D BY REGISTRAR <u>JAN 4 1968</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17572

17577

1 PLACE OF DEATH a COUNTY Prince Georges b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c LENGTH OF STAY IN 1b 6hrs. 27 mins. d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Prince Georges c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt d STREET ADDRESS 221 Lakeside Drive e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary Veronica Schrider				4 DATE OF DEATH Month Day Year Dec. 22, 1967			
5 SEX Female		6. COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH Dec. 8, 1893	
9 AGE (In years last birthday) 74 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11 BIRTHPLAC. County & State, or foreign country) Washington, D.C.	
12 CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Michael P. Lynch			
14. MOTHER'S MAIDEN NAME Mary McQuene				15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			
16 SOCIAL SECURITY NO. none				17 INFORMANT Dr. Alfred P. Schrider Address 1351 Maple Drive, Rockville, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Bronchopneumonia (right lung) 5710 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Severe nutritional Cirrhosis of liver DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 days Year						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) See below death cert							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (1) (physician) attended the deceased from Dec 14 , 19 67 , to Dec. 22, 1967 , that (1) (last) saw the deceased alive on Dec. 22, 1967 , and that death occurred at 9:27 A.M. from causes and on the date stated above							
22a SIGNATURE Till Bergemann M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b DATE SIGNED Dec. 23, 1967	
22c. PHYSICIAN'S NAME (Type) Till Bergemann, M. D.				22d ADDRESS Prof. Bldg., Centerway, Greenbelt, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 12/26/67		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION (City or Town) (County) (State) Silver Spring, Maryland	
24. FUNERAL DIRECTOR Thomas L. Purphey, Inc.				25a REC'D BY REG-STRAR 84 ADDRESS Silver Spring, Md.		25b REGISTRAR'S SIGNATURE Charles Judge	

DATE DEC 28 1967



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <div style="text-align: center; font-size: 1.2em;">PRINCE GEORGES</div> <div style="text-align: right; font-size: 0.8em;">MARYLAND</div> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div style="text-align: center; font-size: 1.2em;">CHEVERLY</div> c. LENGTH OF STAY IN b. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <div style="text-align: center; font-size: 1.2em;">PRINCE GEORGES GENERAL HOSPITAL</div>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <div style="text-align: center; font-size: 1.2em;">MARYLAND</div> b. COUNTY <div style="text-align: center; font-size: 1.2em;">PRINCE GEORGES</div> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div style="text-align: center; font-size: 1.2em;">HILLCREST HEIGHTS</div> d. STREET ADDRESS <div style="text-align: center; font-size: 1.2em;">2215 AFTON STREET</div>	
3. NAME OF DECEASED (Type or print) <div style="text-align: center; font-size: 1.2em;">WILHELM</div>		4. DATE OF DEATH Month Day Year <div style="text-align: center; font-size: 1.2em;">DECEMBER 15 19 67</div>	
5. SEX <div style="text-align: center; font-size: 1.2em;">MALE</div>	6. COLOR OR RACE <div style="text-align: center; font-size: 1.2em;">WHITE</div>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <div style="text-align: center; font-size: 1.2em;">2/14/08</div>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (County & State, or foreign country) <div style="text-align: center; font-size: 1.2em;">GERMANY</div>		12. CITIZEN OF WHAT COUNTRY? <div style="text-align: center; font-size: 1.2em;">USA</div>	
13. FATHER'S NAME <div style="text-align: center; font-size: 1.2em;">FREDERICK SCHULTE</div>		14. MOTHER'S MAIDEN NAME <div style="text-align: center; font-size: 1.2em;">HENRIETTA ARND</div>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <div style="text-align: center; font-size: 1.2em;">NO</div>		16. SOCIAL SECURITY NO. 	
17. INFORMANT <div style="text-align: center; font-size: 1.2em;">MARIA A. SCHULTE</div>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO HYPERTENSIVE CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 44 yrs DUE TO 4 yrs (c)	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <div style="text-align: center; font-size: 1.2em;">19</div>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/4 1966 to 12/15 1967 that (I) (we) last saw the deceased alive on 12/15 1967 and that death occurred at 9:20 A.M. from the causes and on the date stated above.			
22a. SIGNATURE <div style="text-align: center; font-size: 1.2em;">Leo A. Mugmon</div>		22b. DATE SIGNED <div style="text-align: center; font-size: 1.2em;">12/15/67</div>	
22c. PHYSICIAN'S NAME (Type) <div style="text-align: center; font-size: 1.2em;">LEO A. MUGMON</div>		22d. ADDRESS <div style="text-align: center; font-size: 1.2em;">2711 GAITHER ST HILLCREST HTS.</div>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <div style="text-align: center; font-size: 1.2em;">BURIAL</div>	23b. DATE THEREOF <div style="text-align: center; font-size: 1.2em;">12/18/67</div>	23c. NAME OF CEMETERY OR CREMATORY <div style="text-align: center; font-size: 1.2em;">FORT LINCOLN CEMETERY</div>	23d. LOCATION (City, town or county) (State) <div style="text-align: center; font-size: 1.2em;">PRINCE GEORGES MARYLAND</div>
24. FUNERAL DIRECTOR'S SIGNATURE <div style="text-align: center; font-size: 1.2em;">Robert E. Wilhelm</div>		25a. REC'D BY REGISTRAR DEC 19 1967 25b. REGISTRAR'S SIGNATURE <div style="text-align: center; font-size: 1.2em;">Charles Judge</div>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2

~~XXXXXXXXXX~~

XXXX

XXXX

XXXX

~~XXXXXXXXXX~~

XXXX

~~XXXX~~

XXXX

XXXX

XXXX

XXXX

XXXX

XXXX

XXXX

XXXX

XXXX

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 886-911m 6386 1/10/68 kk

CERTIFICATE OF DEATH

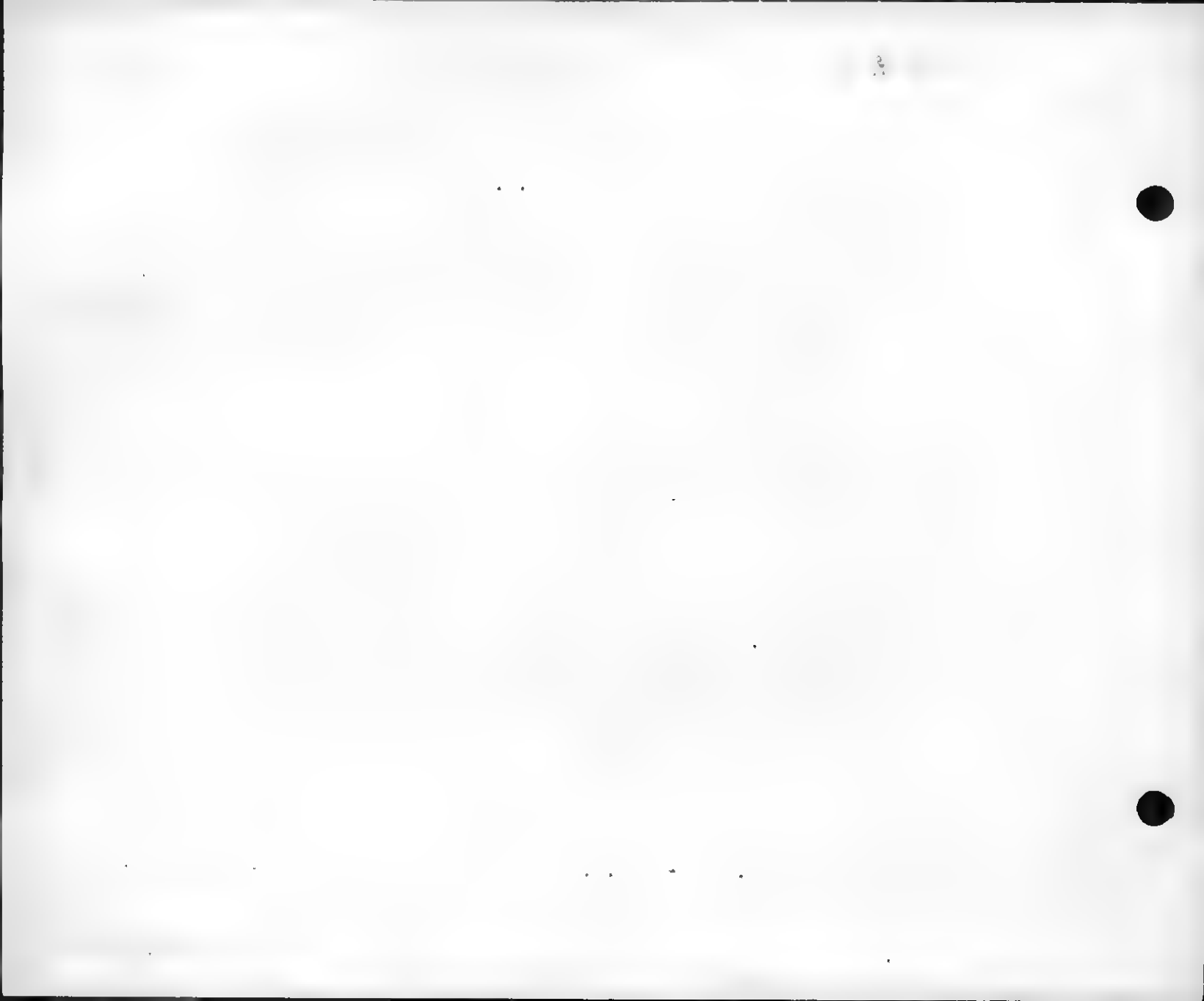
1579

1 PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY P.G.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOWIE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PRINCE GEORGES		d. STREET ADDRESS 12204 MADELEY LANE	
3 NAME OF DECEASED (Type or print) JOAN MAE SCHWENDINGER		4 DATE OF DEATH Month DEC Day 30 Year 1967	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1930 JUNE 24, 1930
9 AGE (In years last birthday) 37 yrs.		10 IF UNDER 1 YEAR Months 30 Days 30 Hours 19 Min 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —	
11 BIRTHPLACE (County & State, or foreign country) HAMDEN, CONN. (NEW HAVEN COUNTY)		12 CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME AXEL SECOR		14. MOTHER'S MAIDEN NAME BERTHA MAE EARLE	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 269-25-8939	
17 INFORMANT HUSBAND		Address 12204 MADELEY	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 484 X IMMEDIATE CAUSE (a) SHOCK DUE TO (b) PULMONARY EMBOLI DUE TO (c) MIGRATORY THROMBOPHLEBITIS		INTERVAL BETWEEN ONSET AND DEATH 3 HOURS 3 DAYS	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARCINOMA OF THE BREAST		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from DEC 28, 1967 to DEC 30, 1967 , that (I) (we) last saw the deceased alive on DEC 30, 1967 , and that death occurred at 2 AM , from causes and on the date stated above.			
22a. SIGNATURE Norman K. Bohrer M.D.		22b. DATE SIGNED Dec 30, 1967	
22c. PHYSICIAN'S NAME (Type) Norman K. Bohrer, M.D.		22d. ADDRESS 3231 Superior Lane, Bowie, Md. 20715	
23a. BURIAL OR CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 1/3/68	23c. NAME OF CEMETERY OR CREMATORY New Haven, Conn.	
24 FUNERAL DIRECTOR Blaugher's Sons 3501-14th Ave.		25a. REC'D BY REGISTRAR DATE JAN 3 1968	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12575

11540

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN b. DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 5903 Westbrook Drive			
3. NAME OF DECEASED (Type or print) First Bernard Middle P. Last Semega				4. DATE OF DEATH Month 12 Day 10 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-16-1915		9. AGE (In years last birthday) 52		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DEPT OF DEFENSE			10b. KIND OF BUSINESS OR INDUSTRY CLASSIFIED		11. BIRTHPLACE (State or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME JACOB SEMEGA				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) YES W.W. II				16. SOCIAL SECURITY NO 176323765		17. INFORMANT MRS FRANCES L. SEMEGA Address SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Occlusion of coronary artery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe M.D.				22. DATE SIGNED 12-11-67			
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC. 14, 1967		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		23d. LOCATION (City or Town) (County) (State) ARLINGTON, VIRGINIA	
24. FUNERAL DIRECTOR W.W. CHAMBERS CO., RIVERDALE, MARYLAND				25a. REC'D BY REGISTRAR DEC 18 1967		25b. REGISTRAR'S SIGNATURE William George	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17581


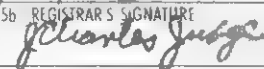
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN TB DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Josephine DiFoe Shavatt				4. DATE OF DEATH 12 2 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 March 1899	9. AGE (In years last birthday) 68 yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR IND. STRY Own Home		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Salvatore DiFeo				14. MOTHER'S MAIDEN NAME Raffaella Ferraiolo			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO. none		17. INFORMANT Frank C. Shavatt Same as #2 (husband) Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH minutes over 5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)				
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe, M.D. M.D.				22. DATE SIGNED 12-3-67			
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REINTERMENT (Specify)		23b. DATE THEREOF 12/6/67		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City or Town) (County) (State) Baltimore Baltimore Md.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md. ADDRESS				25a. REC'D BY REGISTRAR DEC 11 1967		25b. REGISTRAR'S SIGNATURE g Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17582

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			
a. COUNTY Prince Georges MARYLAND				a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN lb 2 yrs, 5 mos 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital				d. STREET ADDRESS 916 - 12th St. N.W.			
3. NAME OF DECEASED (Type or print) First Middle Last Serge Shlopak			4. DATE OF DEATH Month Day Year December 1 1967				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/21/1902		9. AGE (n years last birthday) yrs. 65	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dishwasher		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (County & State, or foreign country) Ukraine, Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Phillip Shlopak				14. MOTHER'S MAIDEN NAME Anna Berizovoskia			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 579-40-4117		17. INFORMANT Address Decedent			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO (b) Generalized arteriosclerosis DUE TO (c) Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: } Cerebral thrombosis with left hemiplegia; bilateral above-knee amputation						INTERVAL BETWEEN ONSET AND DEATH 5 minutes years years	
						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
						20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 6/28 , 19 65 , to 12/1 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12/1 , 19 67 , and that death occurred at 11 P M , from causes and on the date stated above.							
22a. SIGNATURE  22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.				22b. DATE SIGNED 12/1/67		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-6-67		23c. NAME OF CEMETERY OR CREMATORY Rock Creek		23d. LOCATION (City or town) (County) (State) Washington D.C.	
24. FUNERAL DIRECTOR F.J. COLLINS 3821-14th ST. N.W. WASH. D.C.				25a. REC'D BY REGISTRAR DEC 7 1967		25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital				d. STREET ADDRESS 1230 Holbrook Terr., N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ralph Middle L. Last Shorter		4. DATE OF DEATH Month 12/ Day 13/ Year 19 67					
5. SEX M	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/22/29		9. AGE (In years last birthday) 38 yrs	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	11. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine operator		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (County & State, or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Tom Shorter				14. MOTHER'S MAIDEN NAME Rosa Maddox			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes army 1951-53		16. SOCIAL SECURITY NO. 260-36-2113		17. INFORMANT decendent			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE PULMONARY EMBOLI 1222 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) PRIMARY MYOCARDIAL DISEASE (c) 12 YRS						INTERVAL BETWEEN ONSET AND DEATH 2 WKS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC ALCOHOLISM						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11/8/ , 1967 , to 12/13/1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12/13/1967 , and that death occurred at 9:15PM , from causes and on the date stated above.							
22a. SIGNATURE Moe Weiss				22b. DATE SIGNED 12/13/67		22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.	
22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 12-12-67		23c. NAME OF CEMETERY OR CREMATORY HARMONY MEMORIAL CEMETERY		23d. LOCATION (City or town) (County) (State) PRINCE GEORGE CO. ME.	
24. FUNERAL DIRECTOR John J. Phinney & Co., 3015-12th St. N.E.				25a. REC'D BY REGISTRAR DEC 18 1967		25b. REGISTRAR'S SIGNATURE William J. Judge	



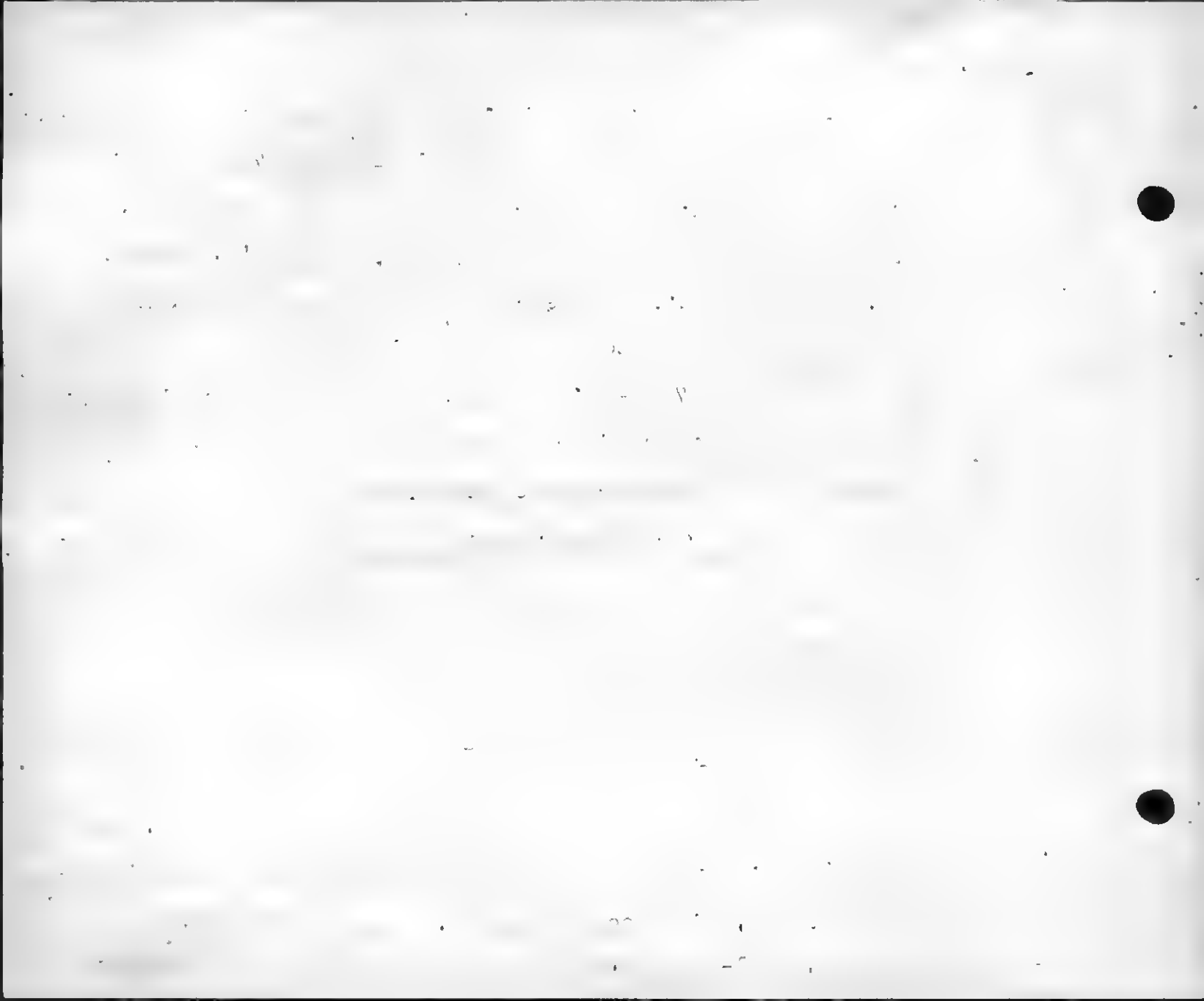
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

17579										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										17584																																							
1 DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First Alice Middle Melissa Last Shreve										Month December Day 31 Year 1967										A.M. 6:50																																							
3. SEX Female										4 RACE White										5 DATE OF BIRTH August 29, 1881										6 AGE (in years last birthday) 86 YRS.										7 UNDER 1 YEAR MONTHS DAYS HOURS MIN										8 UNDER 24 HRS. HOURS MIN									
7a. BIRTHPLACE (State or foreign country) Maryland										7b. CITIZEN OF WHAT COUNTRY? United States										8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9 COUNTY OF DEATH Prince George Md.																													
10 CITY OR TOWN OF DEATH Hyattsville										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sacred Heart Home										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife Ret'd.										12b. KIND OF BUSINESS OR INDUSTRY Lansburgh																													
13a. U.S.A. RESIDENCE (Where deceased lived, if institution-Residence before admission) STATE D. of C.										13b. COUNTY D.C.										13c. CITY OR TOWN Washington										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER 402 H Street, N.E.																			
14. FATHER'S NAME First Aloysius Middle G. Last Jarboe										15. MOTHER'S MAIDEN NAME First Catherine Middle Tennisson Last										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)										16b. SOCIAL SECURITY NO. 577-01-5512										17. INFORMANT Address Sacred Heart Home, Hyattsville, Maryland																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute pulmonary edema 3 days										DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic heart disease										DUE TO, OR AS A CONSEQUENCE OF (c) adeno virus infection										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days																													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)										21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from 11-5, 1959, to 12-31, 1967, that (I) (we) lost saw the deceased alive on 12-30, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE Thomas F. Collins										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED Jan. 1st 1968																													
22d. PHYSICIAN'S NAME (Type) Thomas F. Collins, M.D.										22e. ADDRESS 322 H Street, N.E., Washington, D.C.										23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE Jan 3, 1968										23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cem.										23d. LOCATION (City or Town) (County) (State) Washington DC									
24. FUNERAL DIRECTOR Simmons Bros. 1661-Good Hope RD SE										ADDRESS Wash DC										25a. REC'D BY REGISTRAR DATE 3 1968										25b. REGISTRAR'S SIGNATURE Charles Judge																													

MEDICAL CERTIFICATION



4 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

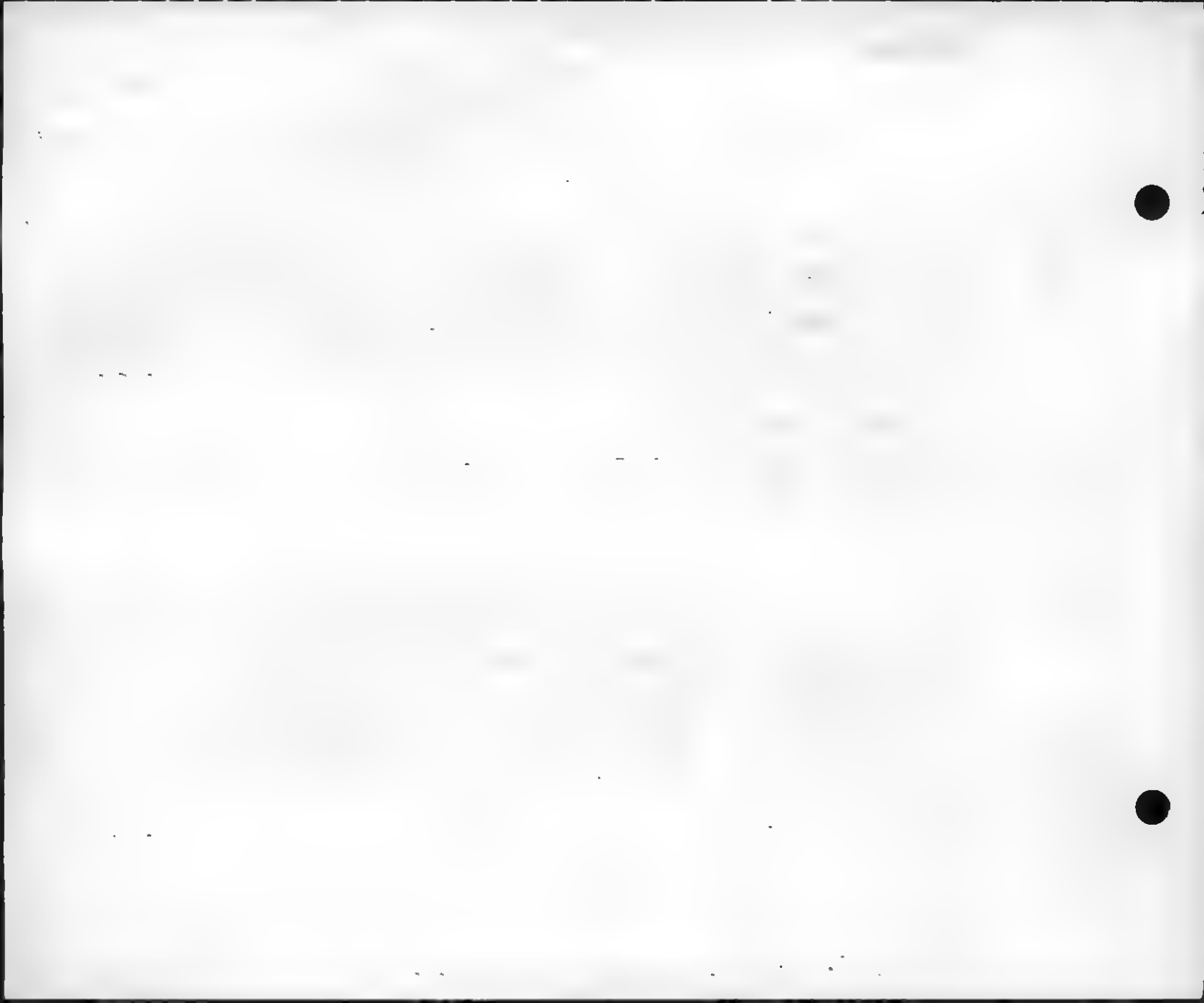
MARYLAND STATE DEPARTMENT OF HEALTH

6530 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17585

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u>		c. LENGTH OF STAY IN 1b <u>2 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>2 L Laurel Hill Road</u>				d. STREET ADDRESS <u>2 L Laurel Hill Road</u>			
3. NAME OF DECEASED (Type or print) <u>Clarence Eugene Siefer</u> First Middle Last				4. DATE OF DEATH <u>December 2, 1967</u> Month Day Year			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Aug 24, 1896</u>		9. AGE (In years last birthday) <u>71</u> yrs	10. UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oil Well Driller</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George McClellan Siefer</u>				14. MOTHER'S MAIDEN NAME <u>Lizzie Brown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>509-10-0812</u>		17. INFORMANT Address <u>Mrs. Lula Siefer 2 L Laurel Hill Road</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>arteriosclerosis heart disease</u> DUE TO (c) <u>with previous myocardial infarct</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital), attended the deceased from <u>Aug 12, 1965</u> , to <u>Dec 2, 1967</u> , that (I) (we) last saw the deceased alive on <u>Aug 2, 1967</u> , and that death occurred at <u>5:30</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Tilber Bergehan</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>Dec. 2, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>TILBERBERGEHAN</u>				22d. ADDRESS <u>Greenbelt Prof. Buddy Greenwell 140</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/6/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Franklin Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Franklin Pennsylvania</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey Inc.</u>				25a. REC'D BY REGISTRAR <u>DEC 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

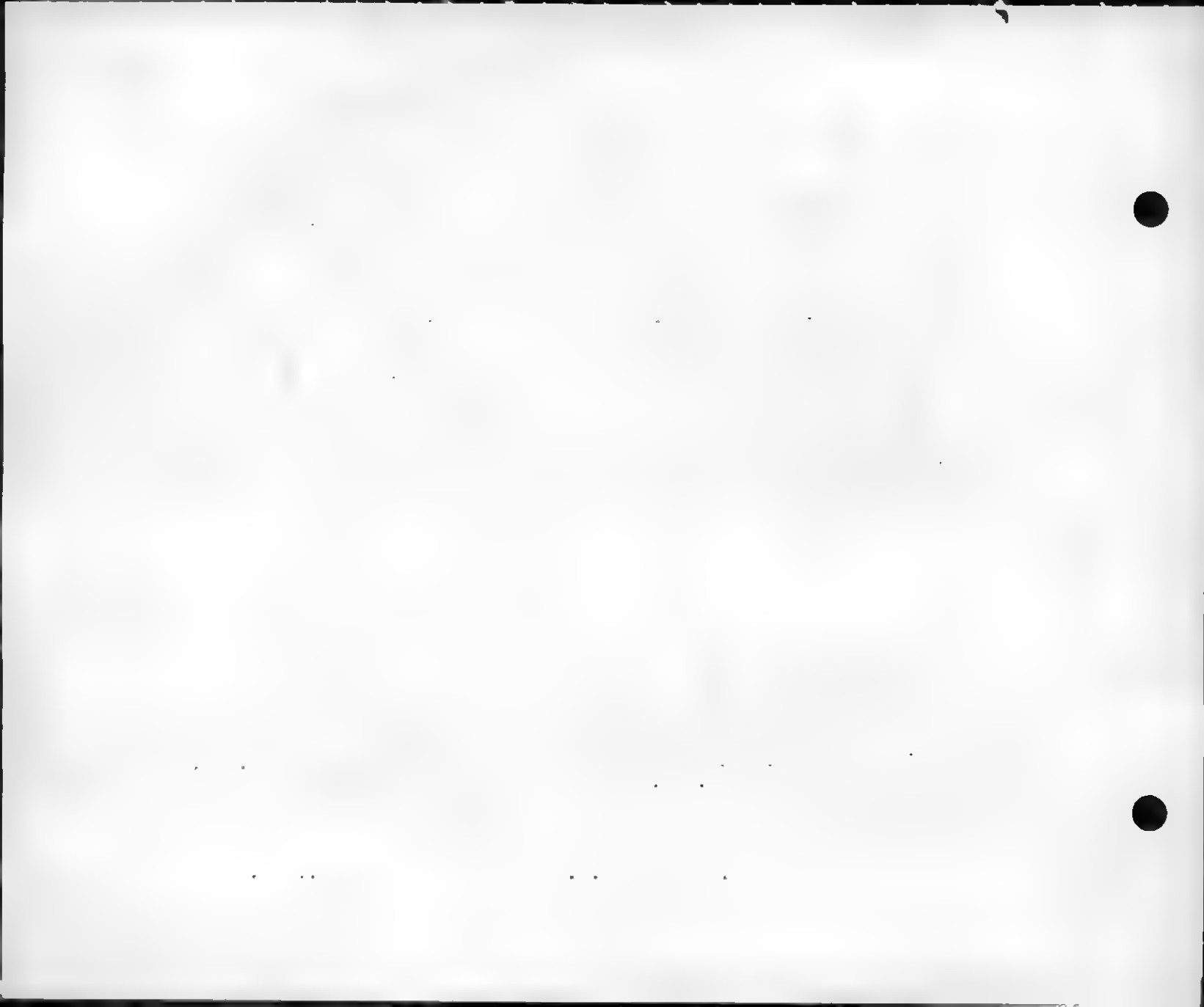
VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17586

1 PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY in 1b 8 days		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) University Park		d. STREET ADDRESS 4440 Wells Parkway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>															
3 NAME OF DECEASED (Type or print) First Middle Last Georgia E. Simmons		4. DATE OF DEATH Month Day Year December 17, 1967		5 SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 23, 1981		9 AGE (In years last birthday) 86 yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Hours Min							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Home		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Cabaret Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John W. Skinner		14. MOTHER'S MAIDEN NAME Jane R. Hammett		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-56-0719		17. INFORMANT Mrs. Eileen Henderson, Hyattsville, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) Bronchiectasis, extensive DUE TO (c) Emphysema of Lungs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) James D. Comeau attended the deceased from June, 1960 , to Dec. 17, 1967 , that (I) (not) last saw the deceased alive on Dec. 17, 1967 , and that death occurred at 7:45 PM , from causes and on the date stated above.		22a. SIGNATURE James D. Comeau M.D.		22b. DATE SIGNED 12/18/67		22c. PHYSICIAN'S NAME (Type) Normal D. Comeau, M.D.		22d. ADDRESS 3503 Perry St., Mt. Rainier, Maryland		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 20, 1967		23c. NAME OF CEMETERY OR CREMATORY Central Cemetery		23d. LOCATION (City or town) (County) (State) Baltimore, Md.		24. FUNERAL DIRECTOR A.G. Hershman & Son, Baltimore, Md.		25a. REC'D BY REGISTRAR DEC 19 1967		25b. REGISTRAR'S SIGNATURE John Charles Jones	



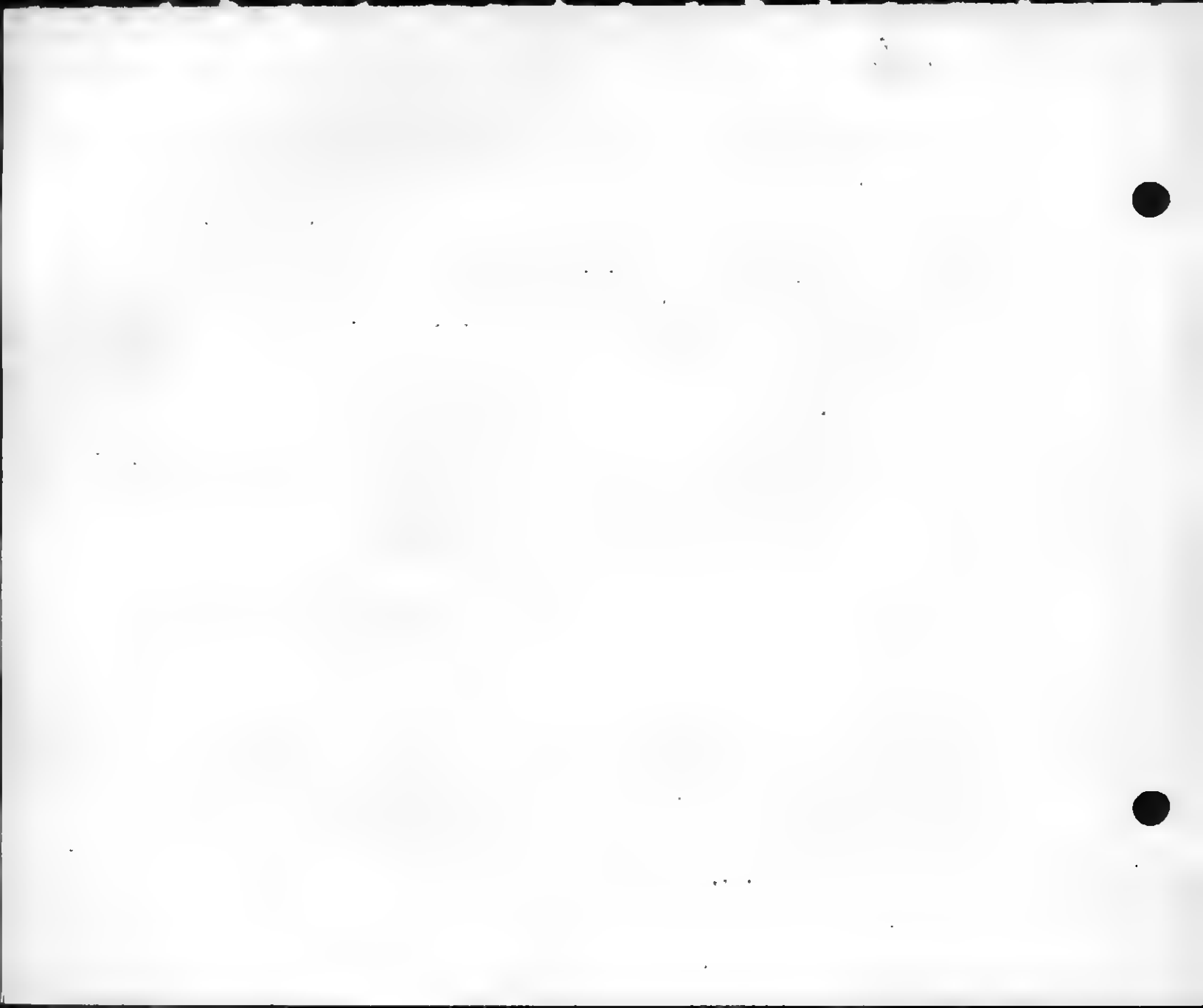
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be enclosed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

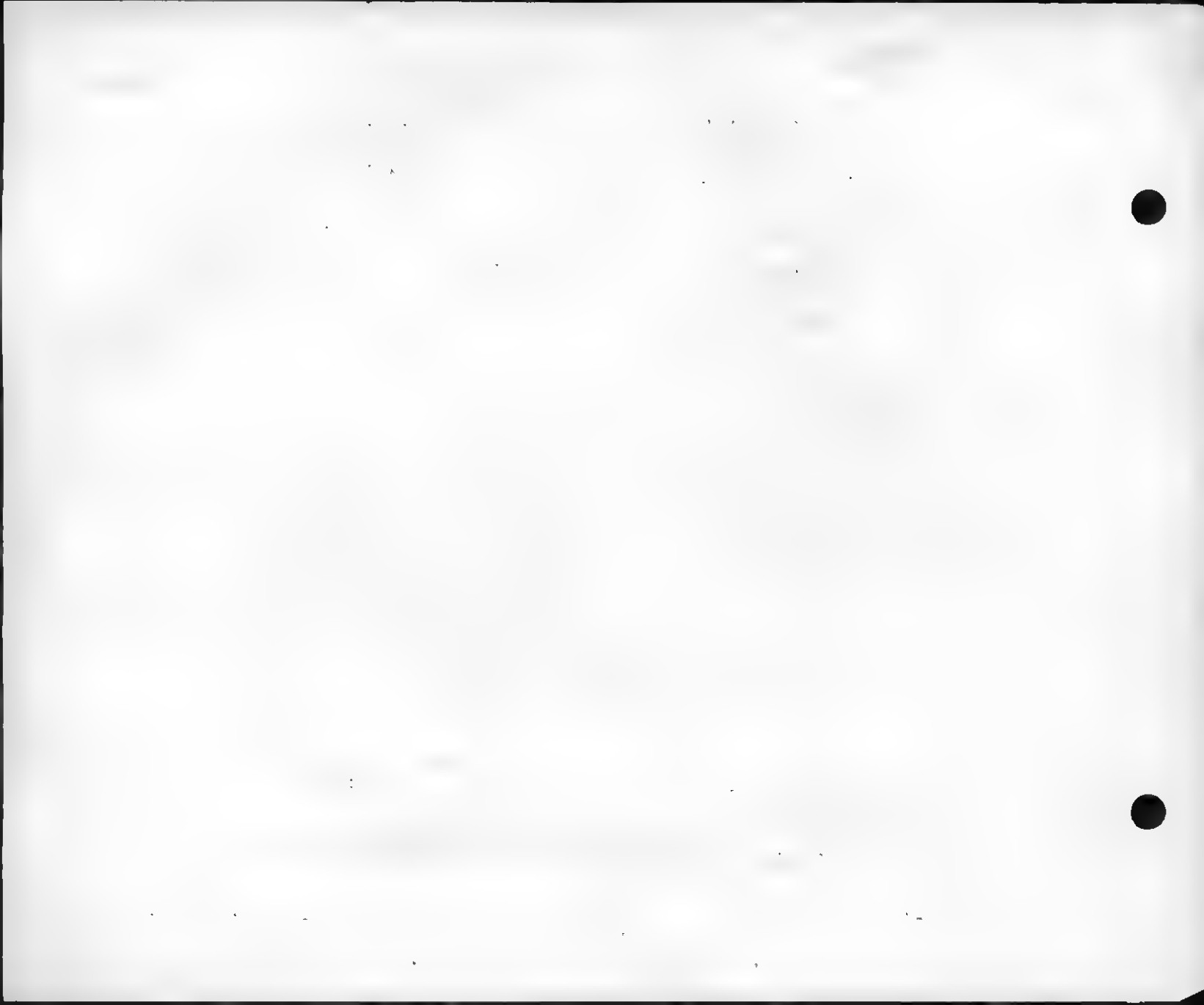
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill	
c. LENGTH OF STAY IN 1b DOA		d. STREET ADDRESS 5028 Livingston Terrace	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital			
3. NAME OF DECEASED (Type or print) First Middle Last Earl Eugene Sizer		4. DATE OF DEATH Month Day Year 12 24 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1904
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mellon Pharmacy		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A.	
13. FATHER'S NAME Charles Sizer		14. MOTHER'S MAIDEN NAME Mary ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Charles Sizer		Address Falls Church, Va	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		22. DATE SIGNED 12-26-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12.29.67	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Suitland Maryland	
24. FUNERAL DIRECTOR J. William Lee's Sons, Co		25a. REC'D BY REGISTRAR JAN 2 1968	
ADDRESS 300.4th st N E		25b. REGISTRAR'S SIGNATURE James Judge	



CERTIFICATE OF DEATH

Page 4 may be retained by the director, page 3 should be filed with the funeral director.

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>12/18/67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Brookside Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Scottsville, Michigan</i>
24. FUNERAL DIRECTOR <i>Falls Church Funeral Home</i> <i>1102 W. Broad St., Falls Church, Va.</i>	25a. REC'D BY REGISTRAR <i>DATE DEC 21 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

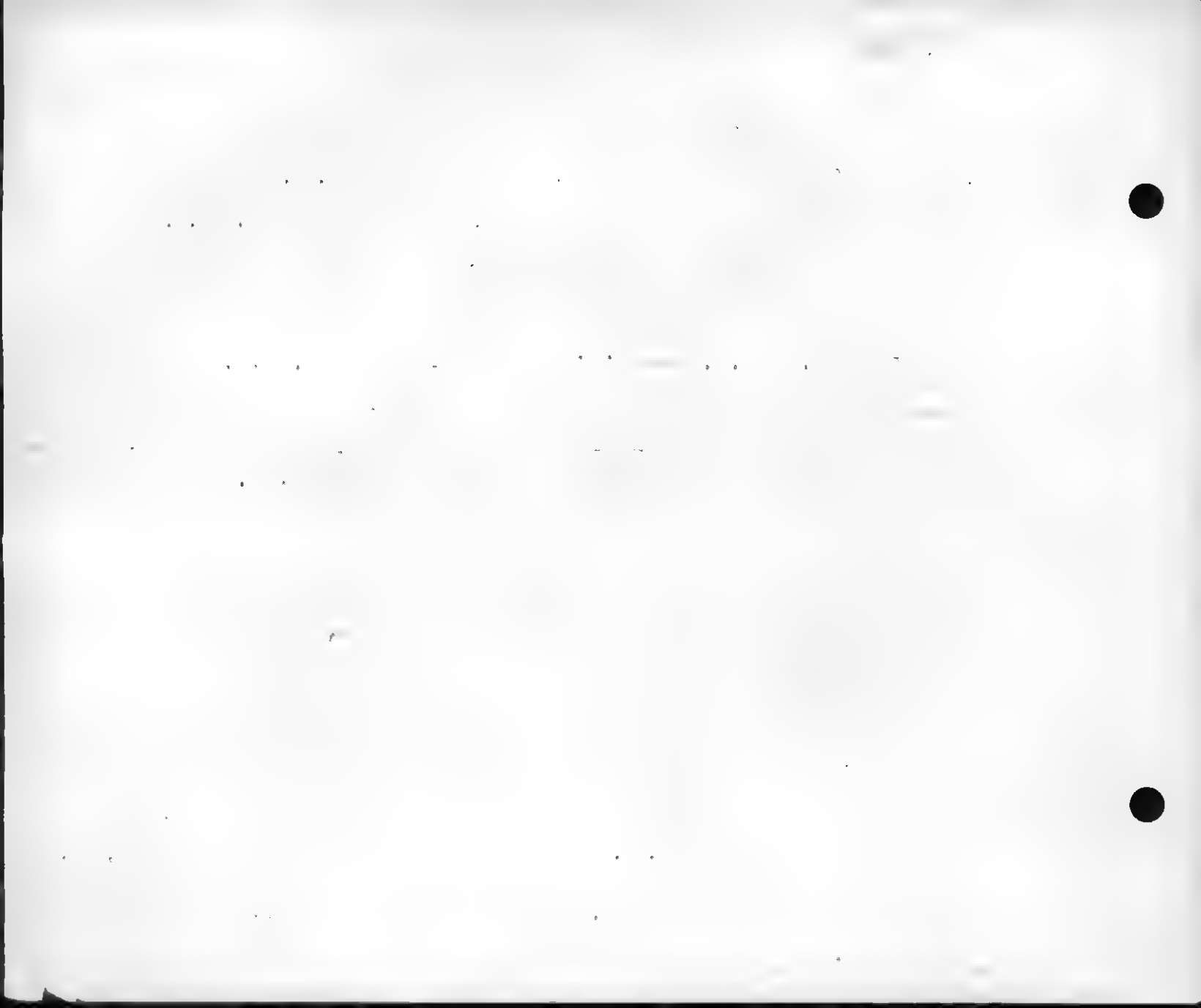
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D. C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 6 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		e. STREET ADDRESS 330 Rhode Island Ave., N.E.	
3. NAME OF DECEASED (Type or print) First Margaret Middle Annie Last Slater		4 DATE OF DEATH Month 12 Day 7 Year 1967	
5 SEX F	6. COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/29/06
9. AGE (In years last birthday) 61 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown Sec. D.P.C.		10b. KIND OF BUSINESS OR IND. SECT. S. Govt.	
11 BIRTHPLACE (County & State, or foreign country) unknown Wash., D.C.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME unknown Milton T. Slater		14. MOTHER'S MAIDEN NAME unknown Mary A. Zelbernagel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO 579-60-7637	
17 INFORMANT Mrs. Regina L. Drye (RFD #2 -Box265-C)		Address decadent	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Pyelonephritis with Papillary necrosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 000.0 (c) 000.0 DUE TO 000.0 DUE TO 000.0 DUE TO 000.0			INTERVAL BETWEEN ONSET AND DEATH 3 Days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of breast with generalized metastasis, left CVA with hemiparesis.			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from 12/27/1967 , to 12/7/1967 , that (X) (we) last saw the deceased alive on 12/7/1967 , and that death occurred at 1:00A M, from causes and on the date stated above.			
22a. SIGNATURE Moe Weiss, M. D.		22b. DATE SIGNED 12/7/67	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/11/1967	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	23d. LOCATION (City or Town) (County) (State) Wash., D.C.
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25a. REC'D BY REGISTRAR DEC 14 1967	
ADDRESS Mt. Rainier Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	



1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12585
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Huntersville Nursing Home</u>		d. STREET ADDRESS <u>3200 16th St. N.W.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARK McMullen Jmeltzer</u>		4. DATE OF DEATH Month Day Year <u>December 3 1967</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>June 6, 1899</u>
9 AGE (in years last birthday) <u>68 yrs.</u>		10 UNDER 1 YEAR Months Days Hours Mins. <u>6 months</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't.</u>	
11 BIRTHPLACE (County & State or foreign country) <u>Baltimore, md</u>		12 CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13 FATHER'S NAME <u>CHARLES MERIKEN</u>		14. MOTHER'S MAIDEN NAME <u>Mollie Gainer</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>577-60-0780</u>	
17. INFORMANT <u>Nursing Home Rec</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> <u>154A</u> DUE TO (b) <u>Carcinoma of the</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u>Primary Carcinoma of the Rectum</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>October 2, 1967</u> , to <u>December 3, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov 9</u> 1967, and that death occurred at <u>5:53</u> P.M. from causes and on the date stated above.			
22a SIGNATURE <u>Harold W. Draper</u>		22b DATE SIGNED <u>Dec 3 1967</u>	
22c PHYSICIAN'S NAME (Type) <u>HAROLD W. DRAPER M.D.</u>		22d ADDRESS <u>911 Silver Spring Ave, Silver Spring, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or town) (County) (State)
<u>BURIAL</u>	<u>12/7/67</u>	<u>Rock Creek Cem</u>	<u>Washington D.C.</u>
24a FUNERAL DIRECTOR <u>John Mann & Son</u>		25a REC'D BY REGISTRAR <u>DEC 6 1967</u>	
ADDRESS <u>5732 Georgia Ave. N.W. Washington D.C.</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

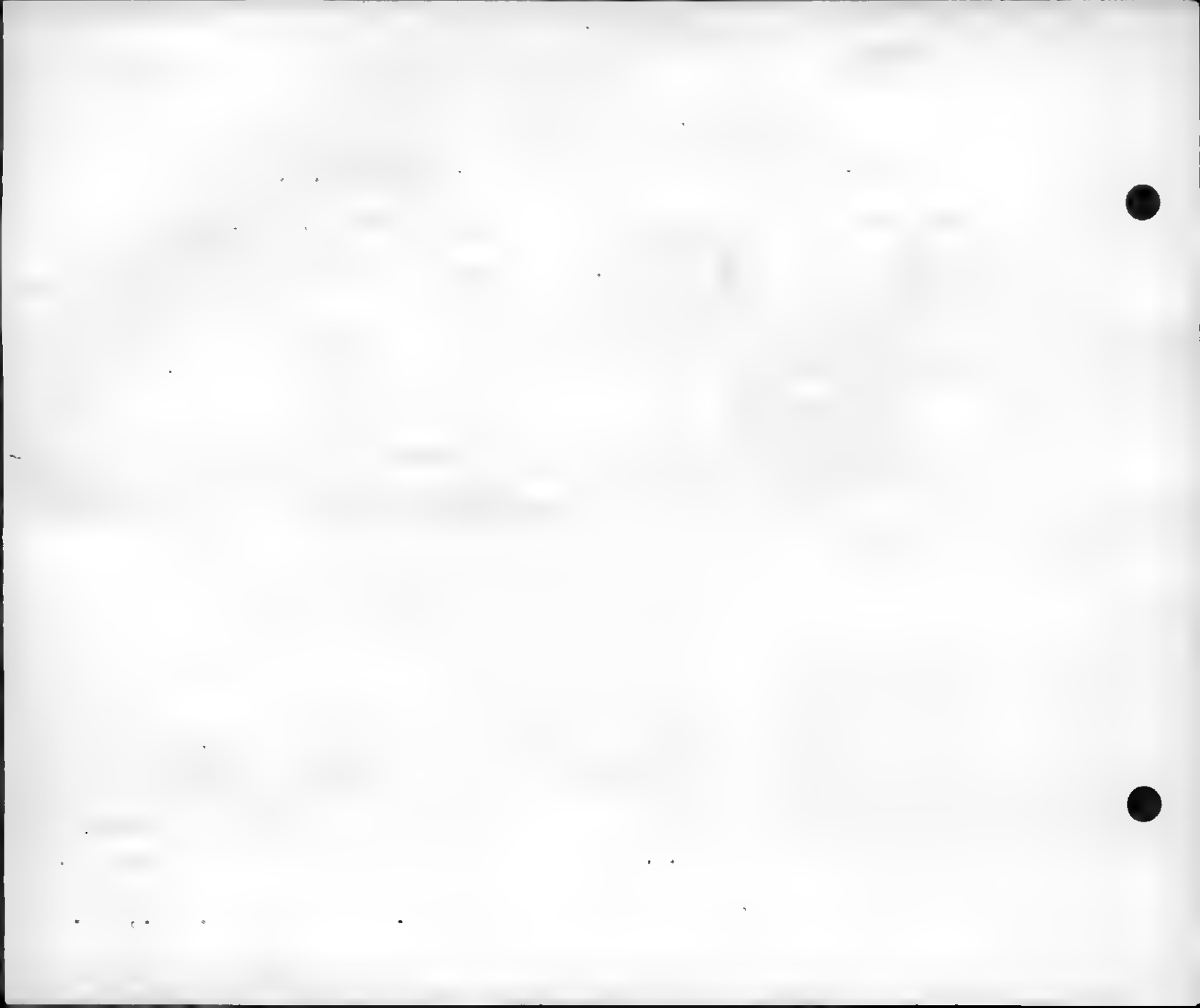
(M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1.591

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		d. STREET ADDRESS 1448 Girard St., N.W.	
3. NAME OF DECEASED (Type or print) First Allie Middle M. Last Smith		4. DATE OF DEATH Month 12 / Day 20 / Year 1967	
5. SEX F	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6/3/21
9. AGE (In years lost birthday) yrs. 46		10. IF UNDER 1 YEAR Months 2 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY Practical Nurse	
11. BIRTHPLACE (County & State, or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Allen Middough		14. MOTHER'S MAIDEN NAME Helen Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 577-30-9173	
17. INFORMANT decedent		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Far advanced pulmonary tuberculosis 0021 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH Diagnosed 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (he) (this hospital) attended the deceased from 11/3/67 to 12/20/1967 , that (he) (we) last saw the deceased alive on 12/20/1967 , and that death occurred at 4:30PM , from causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 12/20/67	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/27/67	
23c. NAME OF CEMETERY OR CREMATORY Nat'l Harmony Mem.		23d. LOCATION (City or Town) (County) (State) Prince Geo. Co., Md.	
24. FUNERAL DIRECTOR Brooks & Allen, 124 Fla. N.W., N.C.		25a. REC'D BY REGISTRAR DEC 28 1967	
25b. REGISTRAR'S SIGNATURE Glenn Dale Hospital			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

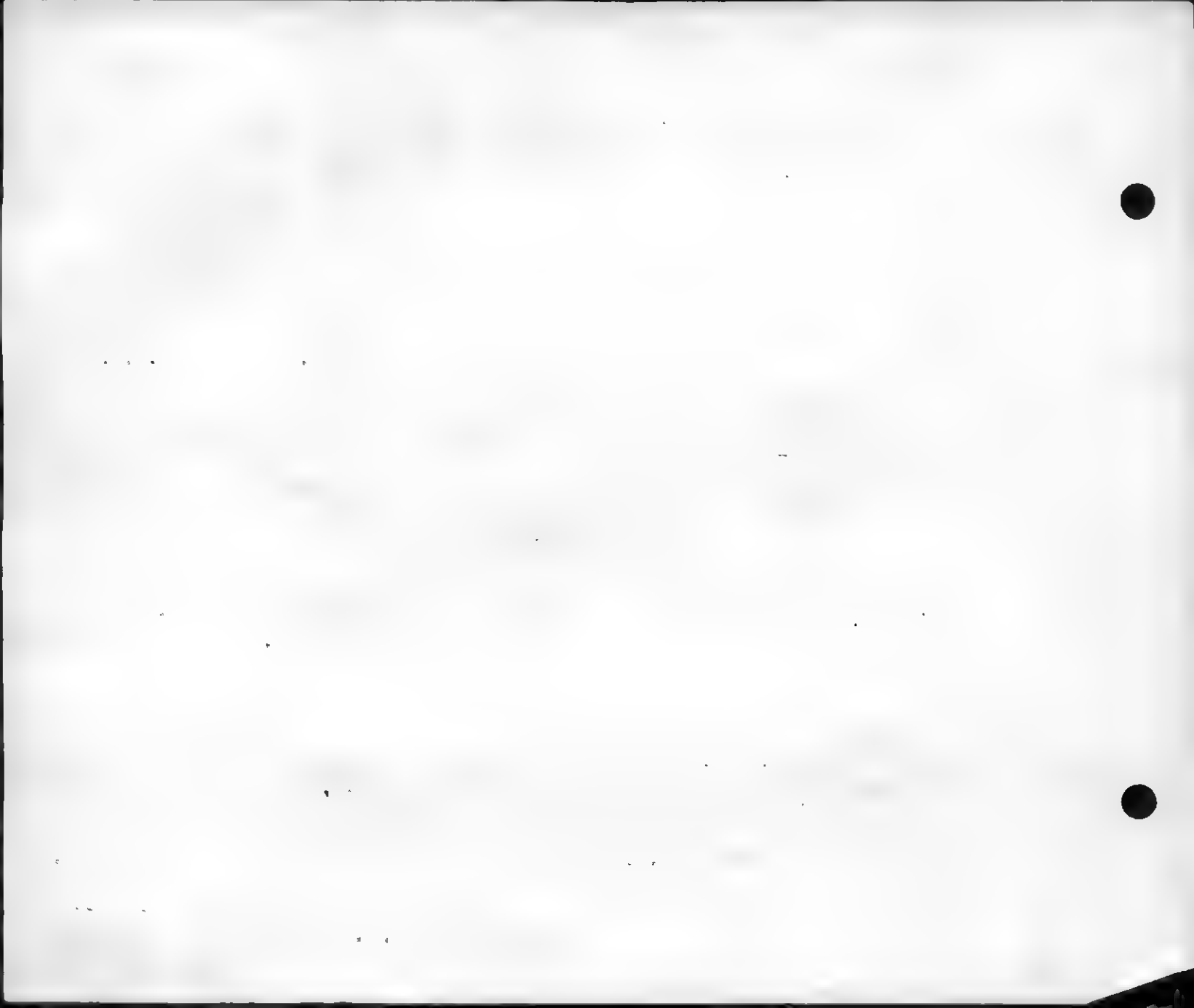
CERTIFICATE OF DEATH

1597

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural (Glenn Dale)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY IN HOSPITAL 14 days		d. STREET ADDRESS 38 Hamilton Street, N.W.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Carroll Middle Smith Last Smith		4. DATE OF DEATH Month December Day 29 Year 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 6, 1900
9. AGE (In years last birthday) 67 yrs		10. F UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bell hop		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) Middleburg, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO unknown	
17. INFORMANT Person		Address and Washington Hospital Center	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Recurrent cerebrovascular accident, probably/ DUE TO (b) cerebral arteriosclerosis DUE TO (c) general arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH one week unknown unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. Diabetic mellitus, hypertensive and arteriosclerotic heart disease; bilateral above knee amputations, right, 1963, left, 1965.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/15 , 1965, to 12/29 , 1967, that (I) (we) last saw the deceased alive on 12/29 1967, and that death occurred at 6:50 M, from causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 12/29/67	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/4/1968	23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial CEM	23d. LOCATION (City or Town) (County) (State) Landover, Md
24. FUNERAL DIRECTOR W. M. Springer		25. REG. BY REGISTRAR 5 1968	

VR A15/16
25M 1/68



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1538

17857

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>N Carolina</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Asheville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12420 Eastgate Lane</u>		d. STREET ADDRESS <u>20 Colonial Place</u>	
3. NAME OF DECEASED (Type or print) <u>HONORIA LILLIAN DECOGAN SMITH</u> First Middle Last		4. DATE OF DEATH <u>Dec 15 1967</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 3/1889</u>
9. AGE (n years last birthday) <u>78</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>County Cork, Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>De Cogan</u>		14. MOTHER'S MARDIN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>WW1</u>		16. SOCIAL SECURITY NO <u>240-78-281</u>	
17. INFORMANT <u>Eileen Bell</u>		Address <u>12420 Eastgate Lane Laurel Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>ATHEROSCLEROSIS</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12/15</u> , 19 <u>67</u> , to <u>12/15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/15</u> , 19 <u>67</u> , and that death occurred at <u>11 A</u> M, from causes on and on the date stated above			
22a. SIGNATURE <u>T. H. ELDER</u>		22b. DATE SIGNED <u>12/18/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>T. H. ELDER</u>		22d. ADDRESS <u>LAUREL, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>Burial</u>	<u>12-19-67</u>	<u>Arlington National</u>	<u>Arlington, Va.</u>
24. FUNERAL DIRECTOR <u>De Witt Danielson Laurel Md</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE	
DATE <u>DEC 27 1967</u>			



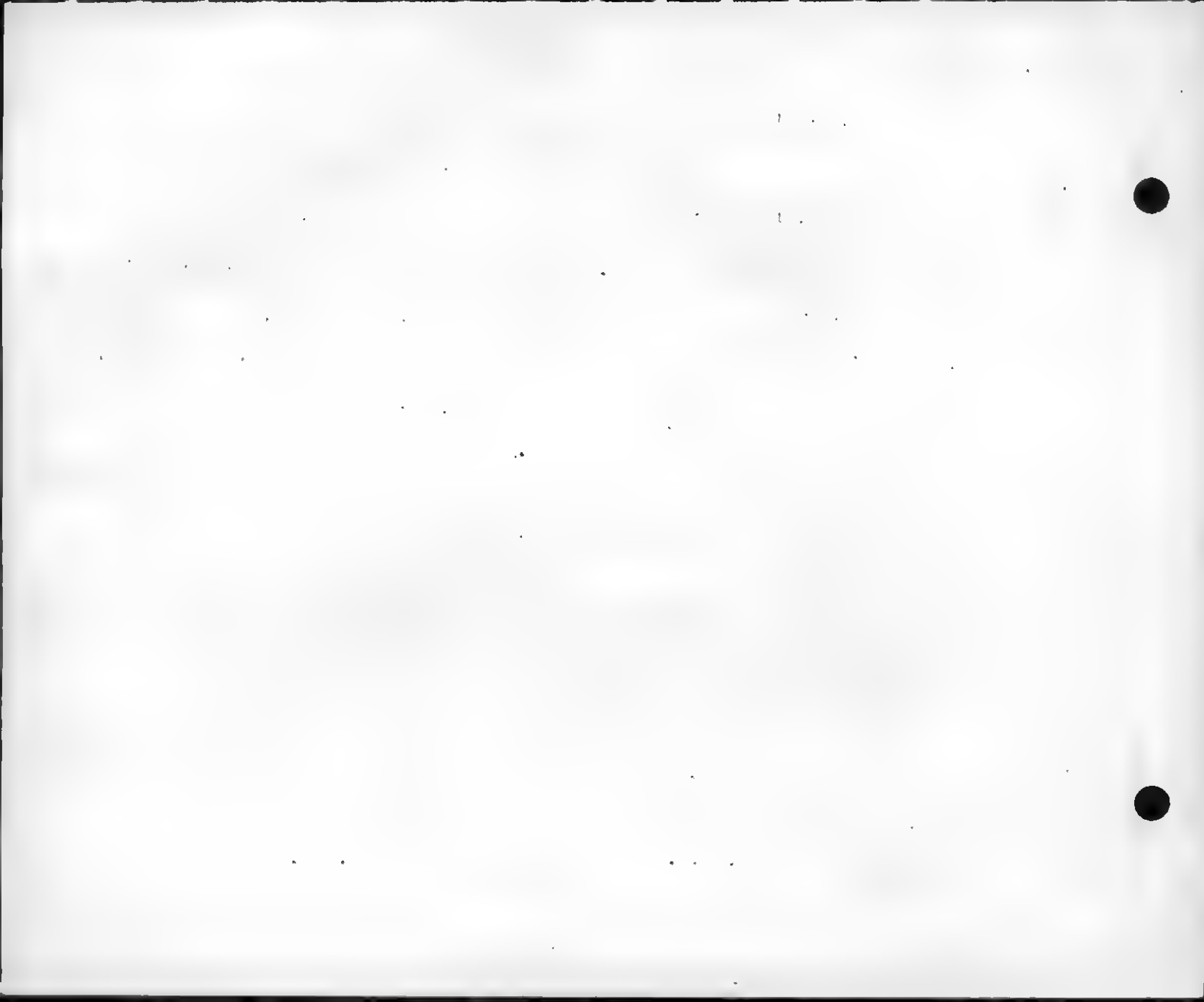
1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) District Heights	
c. LENGTH OF STAY IN 1b DOA		d. STREET ADDRESS 7213 Gateway Drive	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charlotte G. Sondheimer		4. DATE OF DEATH Month Day Year December 28 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 12, 1893
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Burgee		14. MOTHER'S MAIDEN NAME Mary Brewer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Charles Sondheimer		Address Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4300 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH minutes unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type) John Kehoe, M.D.		22. DATE SIGNED 12-28-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-30-1967	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City, town or county) (State) Suitland Prince Geo Md	
24. FUNERAL DIRECTOR Robert A. Mattingly ADDRESS 131-15th St NE Wash D.C.		25a. REC'D BY REGISTRAR DATE DEC 29 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



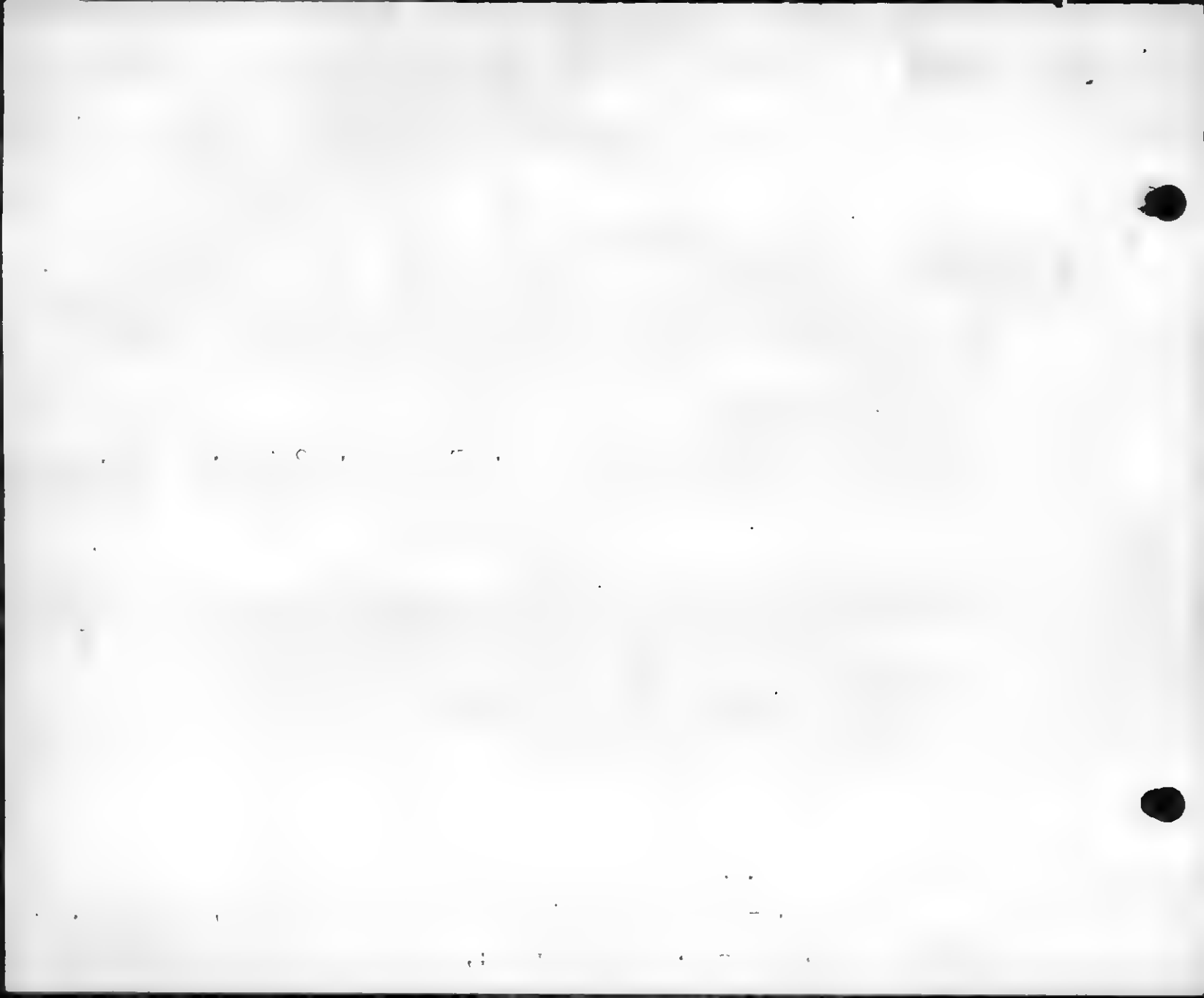
1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form #M3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 17594

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Andrew's Air Force Base Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville d. STREET ADDRESS 5349 Pine Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) Margaret Sarah Soriano		4. DATE OF DEATH 12 30 19 67		5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-10-15		9. AGE (In years last birthday) 52 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Sidney Blackstock				14. MOTHER'S MAIDEN NAME Ann Kidd				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. # 2.				17. INFORMANT Mr. Arsenio F. Soriano.				Address Same as			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Pneumonia and Occlusion of coronary artery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Arteriosclerotic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED 12-31-67 EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland Address (Street, city, town, or county) 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Jan. 3-68 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery 23d. LOCATION (City, town or county) (State) Suitland, Maryland. 24. FUNERAL DIRECTOR Simmons Bros. 1661-Gd. HOPE Rd. WASH., DC 25a. REC'D BY REGISTRAR 3 1968 25b. REGISTRAR'S SIGNATURE Charles Judge																							



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17595

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>LAUREL GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>200. FORT MEAD ROAD</u>			
3. NAME OF DECEASED (Type or print) First <u>JEWEL</u> Middle <u>LEE</u> Last <u>SPAHN</u>				4. DATE OF DEATH Month <u>DEC</u> Day <u>9</u> Year <u>1967</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APR 2, 1897</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>GIBSON CO. TENN.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>VIRGEL JONES</u>			
14. MOTHER'S MAIDEN NAME <u>OLLIE E. WEST</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Atherosclerosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/11, 1967</u> to <u>12/19, 1967</u> , that (I) (we) last saw the deceased alive on <u>12/19, 1967</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Frank L. Vener</u>						22b. DATE SIGNED <u>12/11/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>FRANK L. VENER</u>						22d. ADDRESS <u>320 MONTGOMERY ST. LAUREL, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>12/17/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATL</u>		23d. LOCATION (City, town or county) (State) <u>ARLINGTON VA</u>			
24. FUNERAL DIRECTOR <u>Charles 550</u>				25a. REC'D BY REGISTRAR <u>WASH BND</u>		25b. REGISTRAR'S SIGNATURE <u>Richard J. Judge</u>			
DATE <u>DEC 13 1967</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

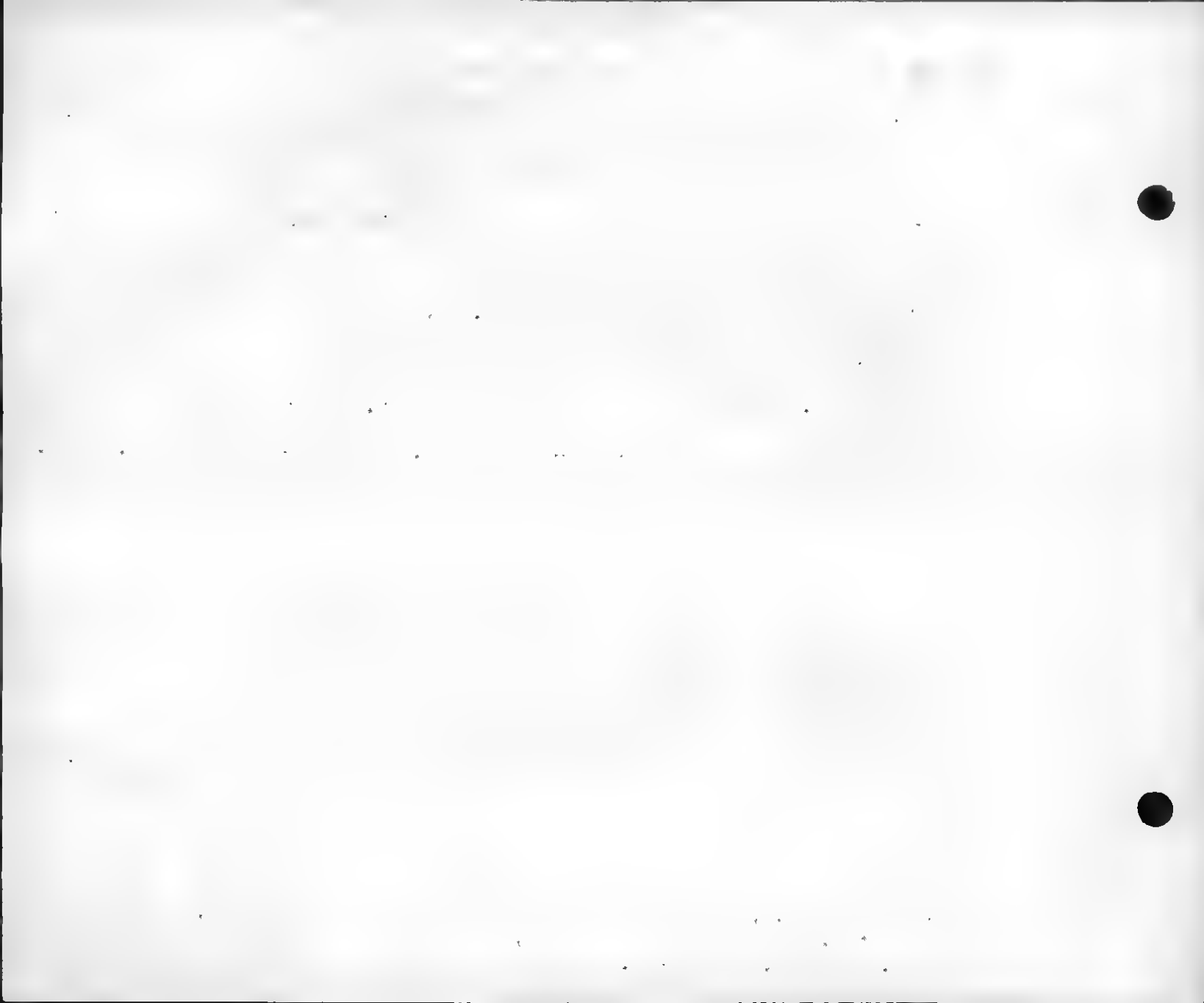
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11596

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi c. LENGTH OF STAY IN IS 2 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9800- Riggs Road			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi d. STREET ADDRESS 9800- Riggs Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Florence Angie Springman f. SEX Female g. COLOR OR RACE White h. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> i. DATE OF BIRTH Oct. 18, 1903 j. AGE (In years) 64 yrs. IF UNDER 1 YEAR: Months 31 Days 1967 IF UNDER 24 HRS: Hours 10 Min 15			4. DATE OF DEATH December 31 1967 k. BIRTHPLACE (County & State, or foreign country) North Carolina l. CITIZEN OF WHAT COUNTRY? USA		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Own home			11. BIRTHPLACE (County & State, or foreign country) North Carolina 12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Edward L. Angle			14. MOTHER'S MAIDEN NAME Flora K. Rivers Ellis		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 578-09-6897-A		
17. INFORMANT Leonard V. Springman Address 9800 Riggs Rd. Adelphi Md.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis DUE TO (b) Arteriosclerotic Cardiovascular disease DUE TO (c) Diabetes mellitus - Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus - Hypertension			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (1) (this hospital) attended the deceased from <u>9-7</u>, 19<u>66</u>, to <u>12-31</u>, 19<u>67</u>, that (we) last saw the deceased alive on <u>12-31</u>, 19<u>67</u>, and that death occurred at <u>11:32</u> AM, from causes and on the date stated above.					
22a. SIGNATURE R.D. Bauer M.D.			22b. DATE SIGNED 12-31-67		
22c. PHYSICIAN'S NAME (Type) R.D. Bauer, M.D.			22d. ADDRESS 2513 Buck Lodge Rd. Adelphi, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Jan. 3, 1968		23c. NAME OF CEMETERY OR CREMATORY George Washington	
23d. LOCATION (City or Town) (County) (State) Hyattsville, Maryland		25a. REC'D BY REGISTRAR Warner E. Pumphrey, Inc 8434-Ga. Avenue			
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JAN 8 1968			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

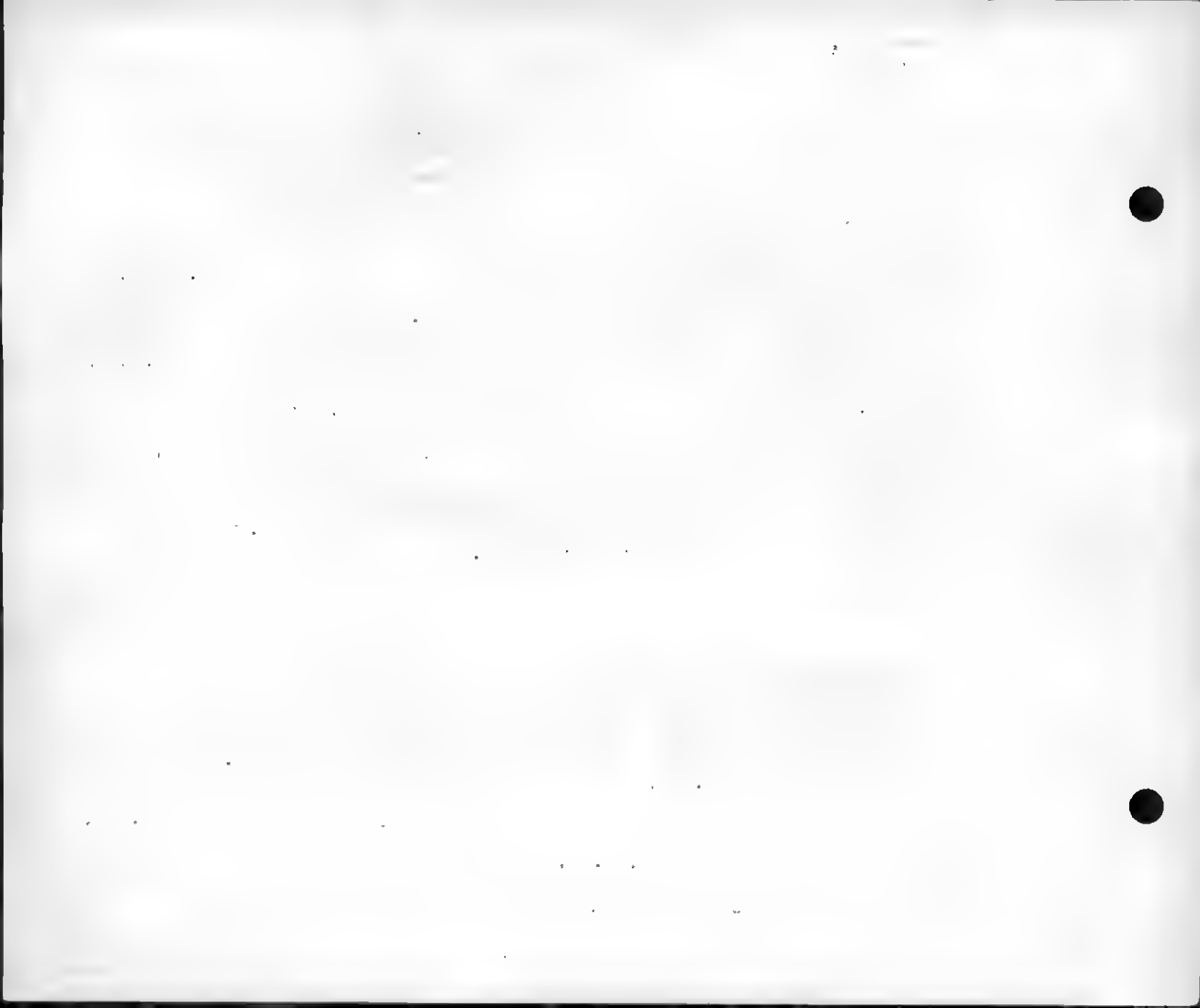


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c LENGTH OF STAY IN 1b 8 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d STREET ADDRESS 6503 Landover Road Apt 101			
3 NAME OF DECEASED (Type or print) First Middle Last Viva Mae Stancil				4 DATE OF DEATH Month Day Year Dec. 10, 1967			
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 25 Oct. 1918		9 AGE (In years last birthday) 49 yrs	10 UNDER 1 YEAR Months Days	11 IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work not be even if retired) Cosmetician			10b. KIND OF BUSINESS OR INDUSTRY Drug Stores		11. BIRTHPLACE (County & State, or foreign country) Texas		12 CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Frank F. Clevenger				14. MOTHER'S MAIDEN NAME Georgia M. Hargrove			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT Address Edwin T. Stancil Same as #2 (husband)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction with DUE TO perforation of interventricular septum. - 9 hours Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Coronary Thrombosis. 8 days DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) this doctor attended the deceased from December 2, 1967 to Dec. 10, 1967 that (I) was last saw the deceased alive on Dec. 10, 1967 and that death occurred at 10 P M , from causes and on the date stated above.							
22a. SIGNATURE Frederick Wilhelm				22b. DATE SIGNED Dec. 11, 1967		22c. PHYSICIAN'S NAME (Type) Frederick Wilhelm, M. D.	
22d. ADDRESS 6319 Landover Road, Cheverly, Maryland				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/14/67		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR DATE DEC 18 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled up by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

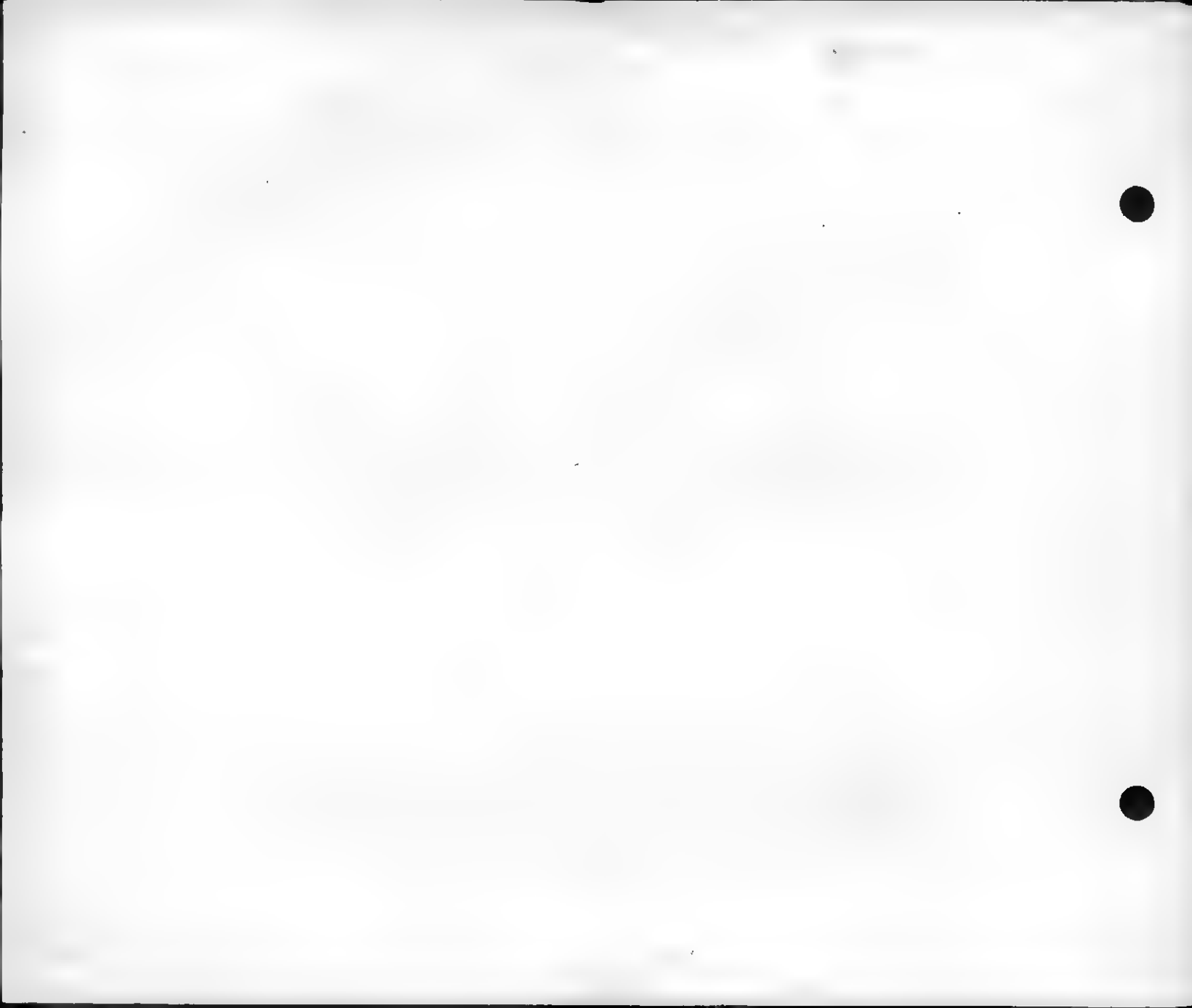
VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1.59N

1 PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a STATE <u>Md.</u> b COUNTY <u>Prince Georges</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham, Md.</u>		c LENGTH OF STAY IN IS <u>9 mo.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Magnolia Gardens Nursing Home</u>		d STREET ADDRESS <u>5518 Volta Ave.</u>	
3 NAME OF DECEASED (Type or print) <u>Madeline M Stanton</u>		4 DATE OF DEATH Month <u>12</u> Day <u>16</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <u>July 25, 1902</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Congressional Secretary U.S. Senate</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Plymouth, Penn.</u>	9 AGE (in years lost birthday) <u>65</u> yrs
11 BIRTHPLACE (County & State, or foreign country) <u>Plymouth, Penn.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Harry Nelson Major</u>		14 MOTHER'S MAIDEN NAME <u>Mae Hughes</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>263-10-2043</u>	
17 INFORMANT <u>Marcia S. Bartlett</u>		Address <u>Same as #2</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 350X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Parkinson's Disease</u> DUE TO (c) <u>2 years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 1967</u> to <u>12/16, 1967</u> that (I) (we) last saw the deceased alive on <u>12/16, 1967</u> , and that death occurred at <u>6</u> M, from causes and on the date stated above.			
22a SIGNATURE <u>Norman D. Comeau</u> M.D.		22b DATE SIGNED <u>12/17/67</u>	
22c PHYSICIAN'S NAME (Type) <u>Norman D. Comeau</u>		22d ADDRESS <u>3503 Pennys Mt Rd, Rainier, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>Dec. 19, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Brooklyn Pa</u>
24. FUNERAL DIRECTOR <u>F. Gasch's Sons</u>		25a. REGD BY REGISTRAR <u>Hyattsville, Md</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>DEC 21 1967</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17599

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville (Landover Estates)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 6807 Fairwood Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Michael Middle E Last Stubbs				4. DATE OF DEATH Month 12 Day 10 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5 Feb. 1947	9. AGE (In years last birthday) 20	IF UNDER 1 YEAR Months 10 Days 19 Hours 67		IF UNDER 24 HRS Months 10 Days 19 Hours 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Snowden A. Stubbs				14. MOTHER'S MARDEN NAME Margaret Engel			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO none		17. INFORMANT Snowden A. Stubbs Same as #2 (father)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Asphyxia DUE TO Drowning Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Epilepsy since childhood						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fell in bathtub during seizure.					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 11:30am 12-10 1967		20d. INJURY OCCURRED Where <input type="checkbox"/> Not Where <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street office bldg., etc.) Home		20f. (City or town) (County) (State) same as #2	
21. I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe, M.D. Riverdale, Md.				22. DATE SIGNED 12-11-67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/13/67		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City or town) (County) Md. Silver Spring Montgomery	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR DEC 18 1967		25b. REGISTRAR'S SIGNATURE <i>Wm. J. Judge</i>	



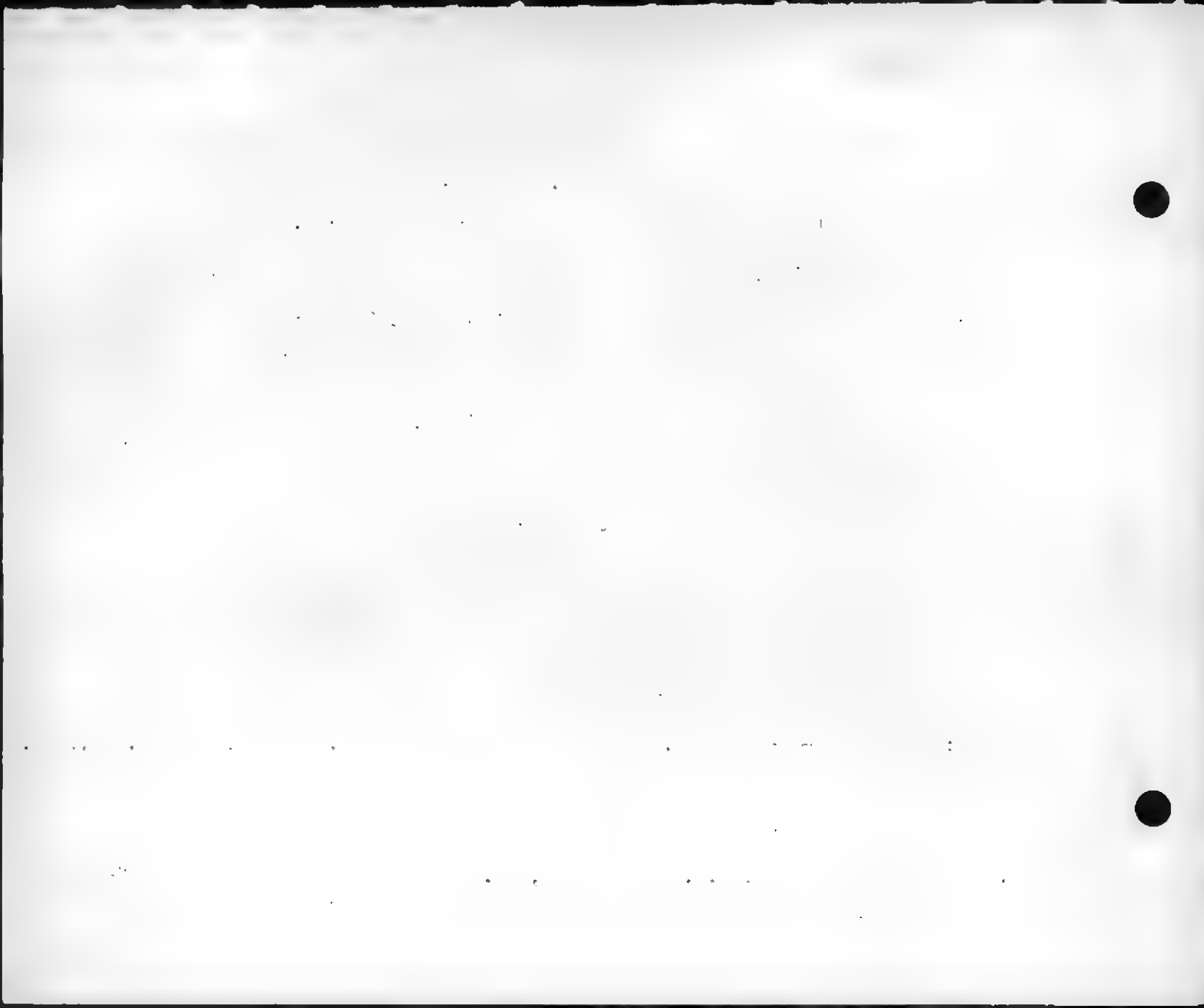
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 17600

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>50 min.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>				d. STREET ADDRESS <u>308 1/2 Main Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Giacomo</u> Middle <u>Sturiale</u> Last <u>Sturiale</u>				4. DATE OF DEATH Month <u>12</u> Day <u>18</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12 June 1922</u>	9. AGE (In years last birthday) <u>45</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>maintenance man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Roads Comm.</u>		11. BIRTHPLACE (State or foreign country) <u>Somerset Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Pietro Sturiale</u>				14. MOTHER'S MAIDEN NAME <u>Mattia Tramba</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>214-42-2921</u>		17. INFORMANT <u>Marie Sturiale</u> Address <u>308 1/2 Main St Laurel Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laceration of brain</u> <u>7124</u> DUE TO <u>Trauma - auto accident</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by auto</u>					
20c. TIME OF INJURY Month, Day, Year <u>1:00pm a.m. 12-18-67</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>West bound lane Rt. 495, Prince Geo. Co., Md.</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.				22. DATE SIGNED <u>12-19-67</u>			
EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u>				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-21-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Emmanuel Cem</u>		23d. LOCATION (City, town or county) (State) <u>Scaggsville Md.</u>	
24. FUNERAL DIRECTOR <u>De Witt Donaldson</u> ADDRESS <u>Laurel Md</u>				25a. REC'D BY REGISTRAR <u>DEC 27 1967</u> 25b. REGISTRAR'S SIGNATURE <u>W. J. Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11601

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE		c. LENGTH OF STAY IN 1b FORESTVILLE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MALCOLM GROW USAF HOSPITAL		d. STREET ADDRESS 3432 LORRING DRIVE	
3. NAME OF DECEASED (Type or print) First Middle Last FRANCIS JOSEPH SUTHONS		4. DATE OF DEATH Month Day Year DECEMBER 7 19 67	
5. SEX MALE	6. COLOR OR RACE CAUC	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 APRIL 1913
9. AGE (In years last birthday) 54 yrs		10. IF UNDER 1 YEAR Months Days Hours Min 10 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED USAF		10b. KIND OF BUSINESS OR IND. STRY US GOVERNMENT	
11. BIRTHPLACE (County & State, or foreign country) BOSTON, MASS.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ALFRED SUTHONS		14. MOTHER'S MAIDEN NAME JENNIE CHALKE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW 11		16. SOCIAL SECURITY NO 031 09 0036	
17. INFORMANT MARIA SUTHONS		Address SAME AS ITEM #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SEPTICEMIA DUE TO (b) PERITONITIS DUE TO (c) CIRRHOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH 24 HR 4 YR
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 8)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (th s hospital) attended the deceased from 25 NOV, 1967 to 7 DEC, 1967 , that (I) (we) last saw the deceased alive on 7 DEC 1967 , and that death occurred at 6:45 P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>Leonard R Farber</i>		22b. DATE SIGNED 7 Dec 67	
22c. PHYSICIAN'S NAME (Type) LEONARD R FARBER CAPT USAF		22d. ADDRESS MALCOLM GROW USAF HOSP ANDREWS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 12/12/67	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY	23d. LOCATION (City or Town) (County) (State) ARLINGTON, VIRGINIA
24. FUNERAL DIRECTOR ROBERT E WILHELM FUNERAL HOME 4308 SUITLAND ROAD, SUITLAND, MARYLAND		25a. REC'D BY REGISTRAR DEC 14 1967	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



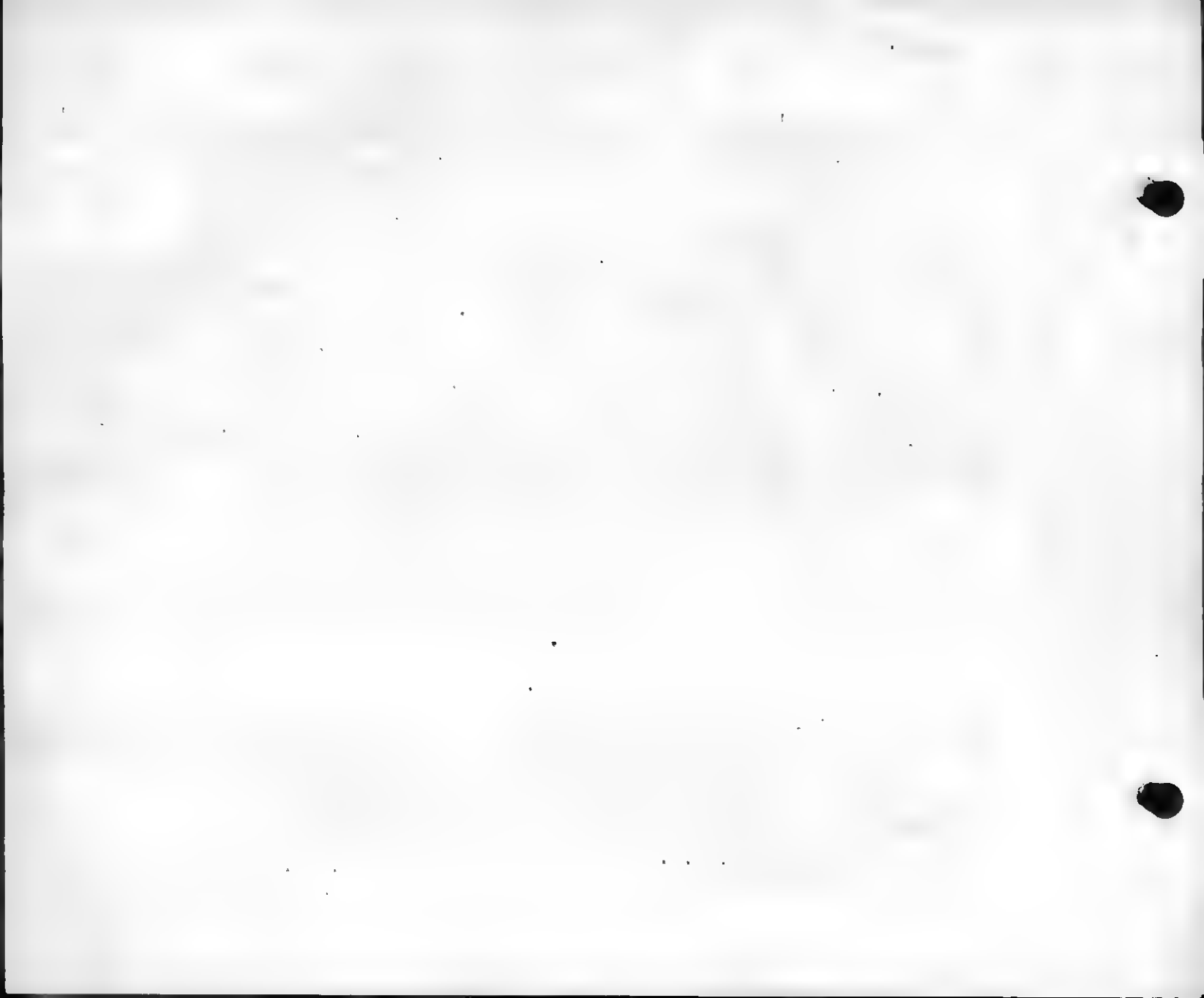
1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDIC-2 EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale					c. LENGTH OF STAY IN 1b DOA				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital					d. STREET ADDRESS 5402 Kenilworth Avenue				
3. NAME OF DECEASED (Type or print) First Middle Last Michael Herbert Sweeney					4. DATE OF DEATH Month Day Year December 26 19 67				
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 21, 1967		9. AGE (In years last birthday) yrs. 5	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOHN E. SWEENEY					14. MOTHER'S MAIDEN NAME CAROLYN FERRELL				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address JOHN E SWEENEY, SAME AS #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural and intracerebral hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO (b) Fall OUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of left tibia 5 days									INTERVAL BETWEEN ONSET AND DEATH 5 days
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Fell at home.					
20c. TIME OF INJURY Month, Day, Year ABOUT 2 PM 12-21-67				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Dec #2	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									22. DATE SIGNED 12-28-67
ACTUAL SIGNATURE John Kehoe, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe, M.D.				ADDRESS (City, town or county) Addressed to, to be					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-29-1967		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem		23d. LOCATION (City, town or county) (State) COLMAR MANOR, MD			
24. FUNERAL DIRECTOR W.W. CHAMBERS Co. RIVERDALE, MD				25a. REC'D BY REGISTRAR DATE JAN 2 1968		25b. REGISTRAR'S SIGNATURE Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

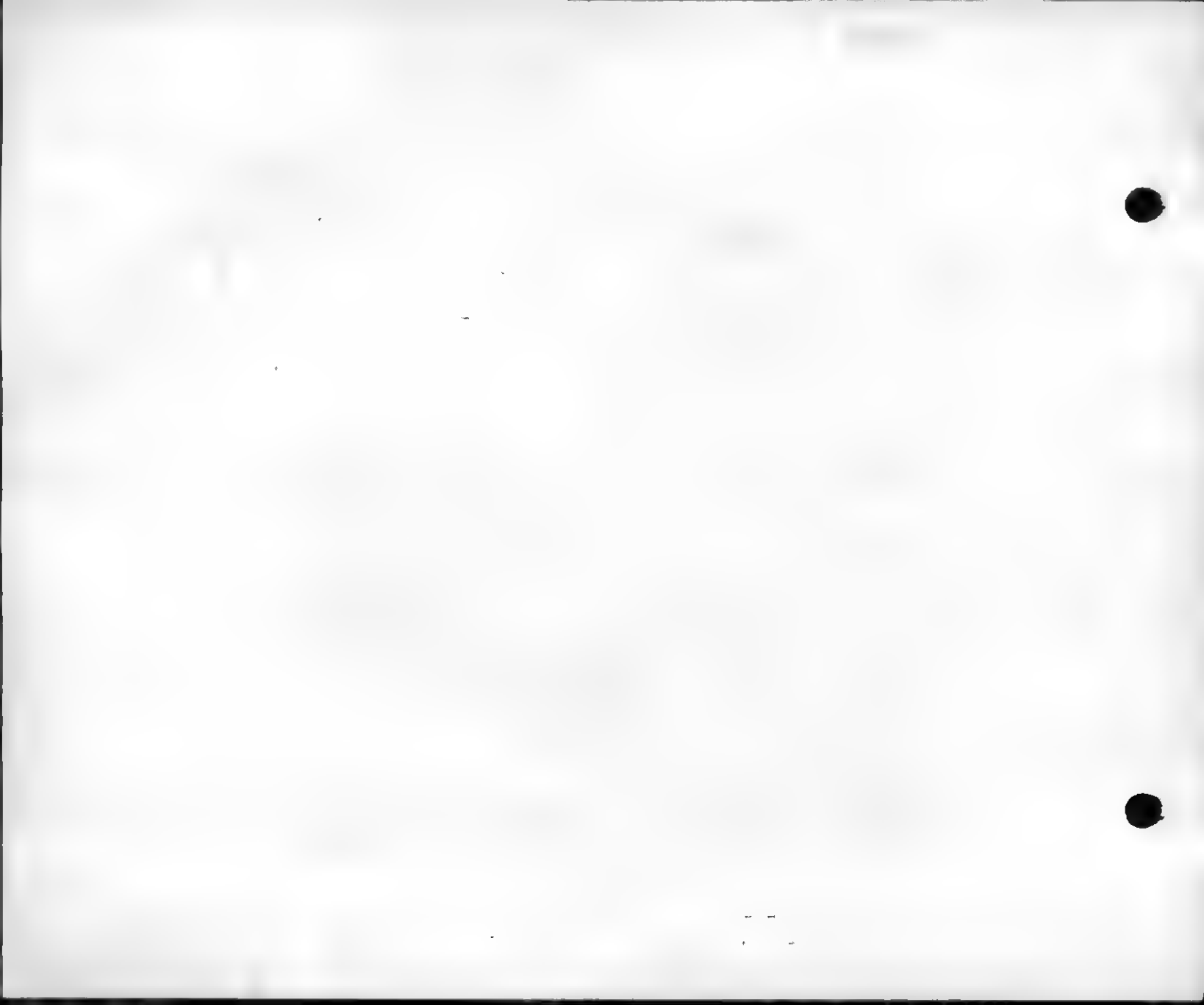
CERTIFICATE OF DEATH

1.603

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forrestville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		d. STREET ADDRESS 6014 Surey Square Lane	
3. NAME OF DECEASED (Type or print) Ruth Sweeney		4. DATE OF DEATH Month 12 Day 6 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8-16-16
9. AGE (in years last birthday) 51 yrs		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Drapery maker		10b. KIND OF BUSINESS OR INDUSTRY Dept. Store	
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Dages		14. MOTHER'S MAIDEN NAME Diamond Valtos	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory & Cardiac Failure DUE TO (b) Metastatic Carcinoma to Lungs & Spine DUE TO (c) Carcinoma of Right Breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Anemia			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour, a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 19, 1960 to Dec. 6, 1967 , that (I) was lost the deceased alive on Dec. 5, 1967 , and that death occurred on Dec. 6, 1967 at 2:30 PM , from causes and on the date stated above			
22a. SIGNATURE Walcutt W. Gibson		22b. DATE SIGNED Dec. 6, 1967	
22c. PHYSICIAN'S NAME (Type) Walcutt W. Gibson, M.D.		22d. ADDRESS 4300 St. Barnabas Road Marlow Heights, Maryland 20031	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-8-1967	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland Maryland	
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road Suitland Maryland		25a. REC'D BY REGISTRAR DEC 11 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

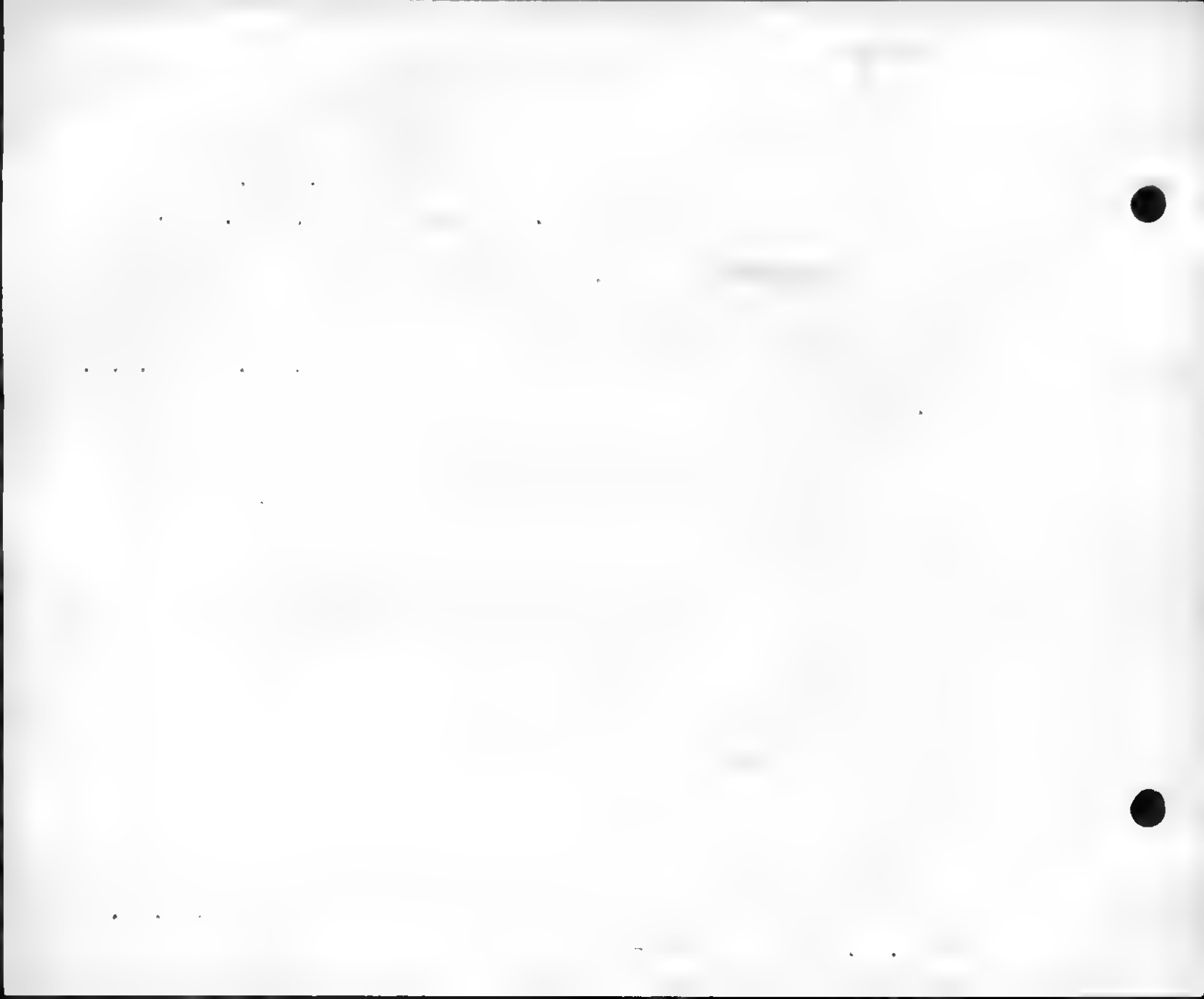
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17600

17604

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Manor-4922 LaSalle Rd.				e. STREET ADDRESS 2480 16th St. N.W. Apt. 527			
3. NAME OF DECEASED (Type or print) First Middle Last Georgie V. Talbert				4. DATE OF DEATH Month Day Year Dec. 22 19 67			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/3/80	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Lovettsville, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME R.M. Jatwell				14. MOTHER'S MAIDEN NAME Carrie Young			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 578-62-4322		17. INFORMANT Address Sister Elizabeth-Carroll Manor			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 451X IMMEDIATE CAUSE (a) Rupture of abdominal aneurysm (1 day) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour 'o m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the physician) attended the deceased from Sept. 14 , 19 65 , to Dec. 22 , 19 67 , that (I) (we) last saw the deceased alive on Dec. 21 , 19 67 , and that death occurred at 6:00 M, from causes and on the date stated above.							
22a. SIGNATURE <i>Thomas F Collins</i>				a. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/22/67	
22c. PHYSICIAN'S NAME (Type) Thomas F Collins, M.D.				22d. ADDRESS 322 H St. N.E. Washington, D.C.			
23a. BURIAL, CREMATION, REMOVA. (Specify) Burial		23b. DATE THEREOF 12/26/67		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D. C.	
24. FUNERAL DIRECTOR The S. H. Hines Company-Washington, DC				25a. REC'D BY REGISTRAR DATE DEC 26 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



17801

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

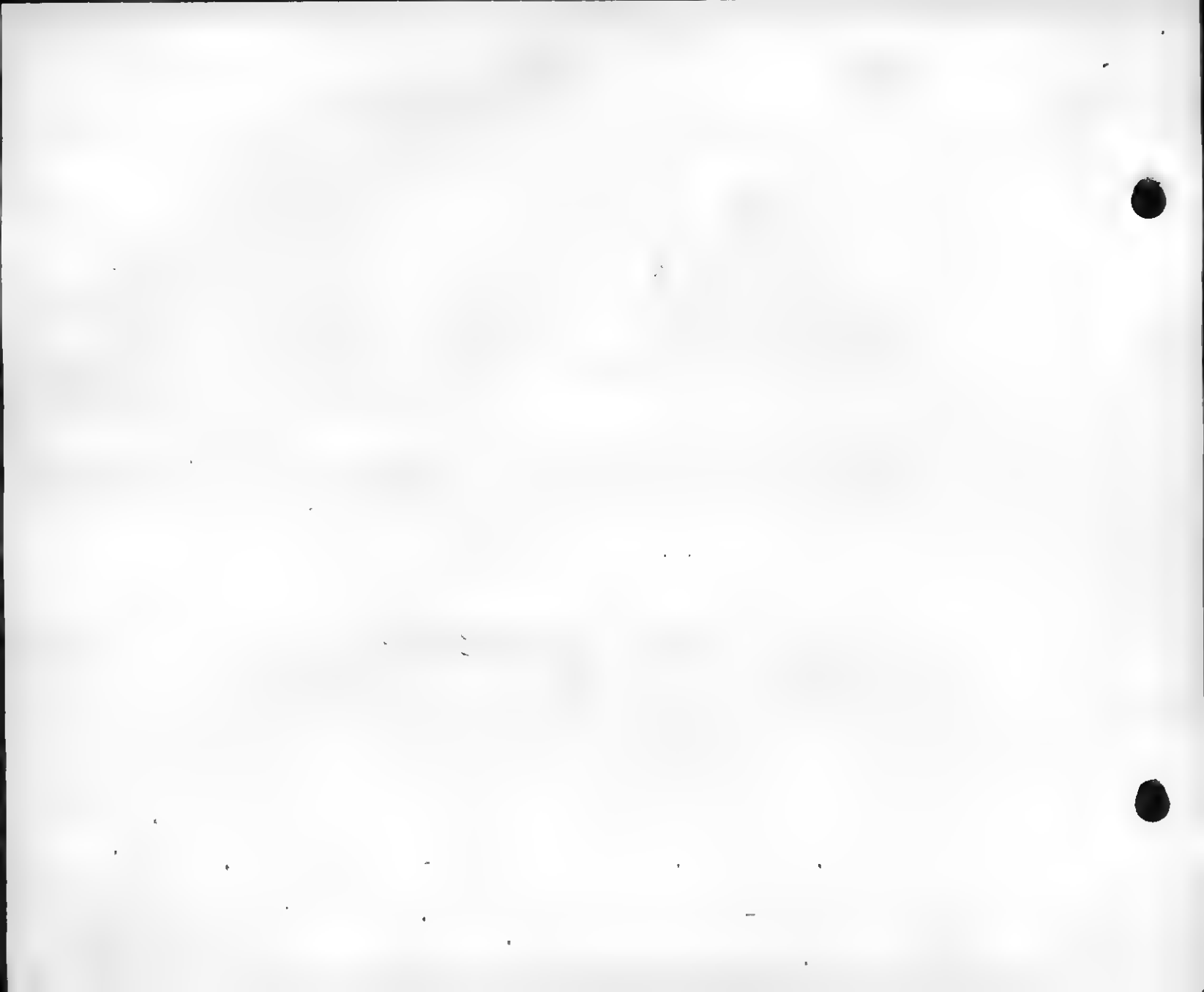
CERTIFICATE OF DEATH

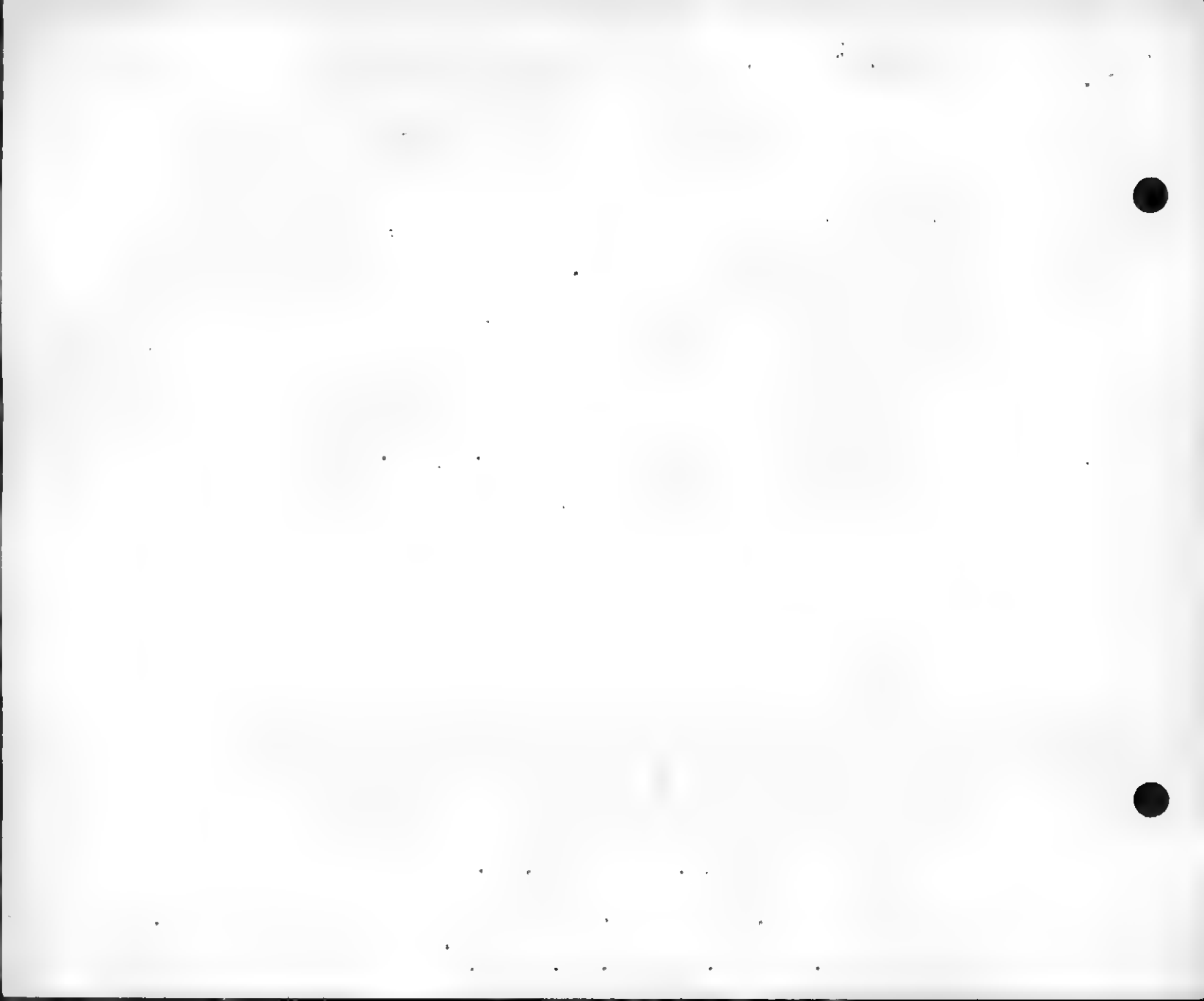
17605

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORESTVILLE</u>		c. LENGTH OF STAY IN 1b <u>10 1/2 mo.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Regent Nursing Home</u>		d. STREET ADDRESS <u>5201 35th AVE.</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>TASCHNER</u> Last <u>TASCHNER</u>		4. DATE OF DEATH Month <u>12</u> Day <u>30</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/4/1884</u>
9. AGE (In years lost birthday) <u>83</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>AUSTRIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SACKS</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Guelner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>John A. Scheibel</u>		Address <u>-6003-Old Branch Ave SE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>+201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 1, 1962</u> to <u>12-30, 1967</u> , that (I) (we) last saw the deceased alive on <u>12-28, 1967</u> , and that death occurred at <u>3:38 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Thomas F. Cleary</u>		22b. DATE SIGNED <u>Dec. 31-1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Thomas F. Cleary</u>		22d. ADDRESS <u>3611-Branch Ave SE, Hillcrest Hght</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 3-1968</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR <u>Simmons Bros</u>		ADDRESS <u>Wash. DC</u>	
25a. REC'D BY REGISTRAR <u>3</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

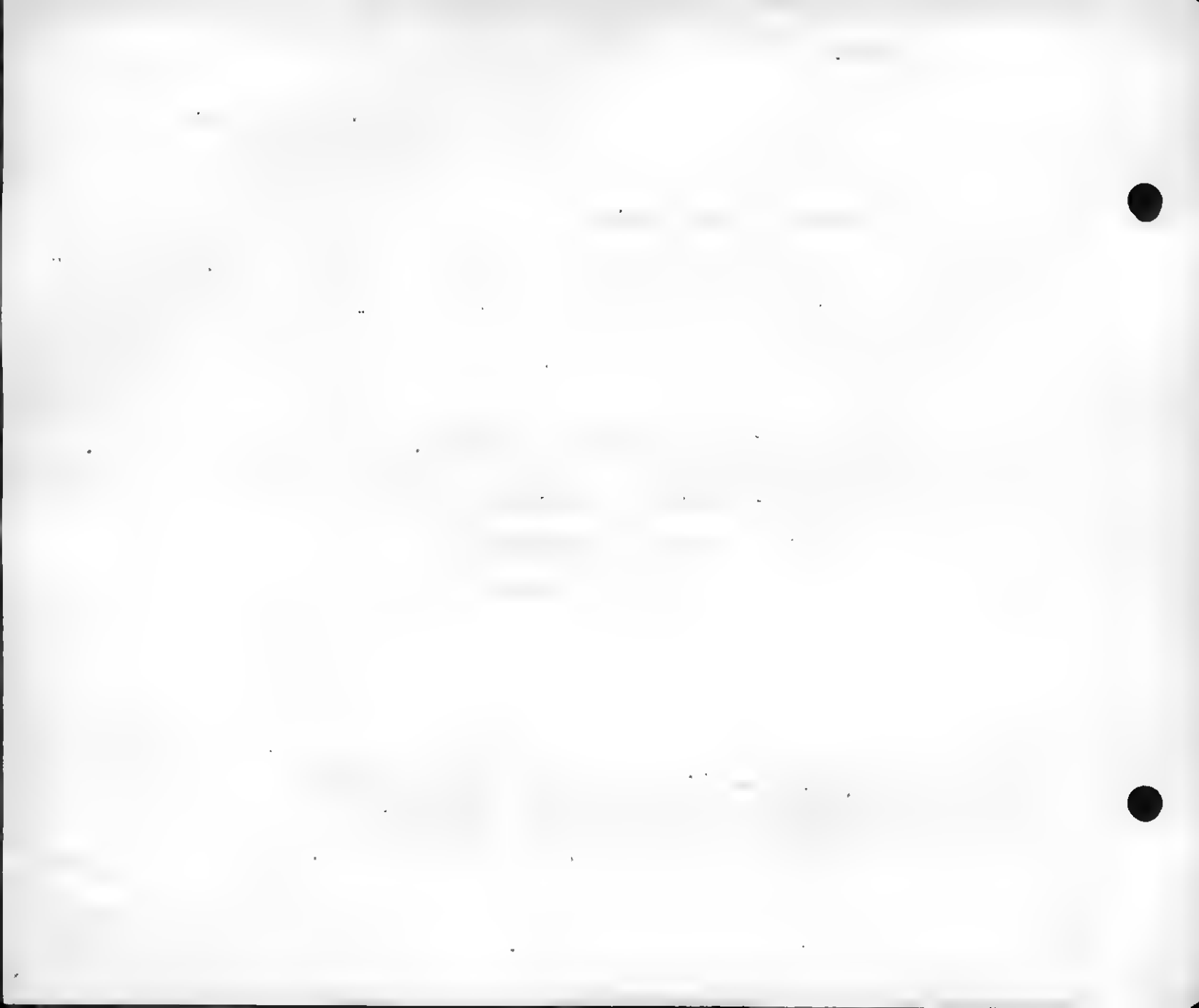
CERTIFICATE OF DEATH

603

604

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 4 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 8604 Caswell Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle John Last Taylor		4. DATE OF DEATH Month Dec. Day 5 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 April 1886
9. AGE (In years lost birthday) 81 yrs		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY school	
11. BIRTHPLACE (County & State, or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Joseph Taylor		14. MOTHER'S MAIDEN NAME Emma unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 210 07 9696	
17. INFORMANT Esther M. Taylor		Address Carrollton Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Invasive cancer of the Stomach DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Abdominal Carcinomatosis DUE TO (c) Generalized Peritonitis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from April , 1965 to Dec. 5 , 1967, that (I) (we) last saw the deceased alive on Dec. 5 , 1967, and that death occurred at 4:45a M. from causes and on the date stated above.			
22a. SIGNATURE William D. Rosson M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) William D. Rosson, M.D.		22d. ADDRESS 5701 85th Ave., Hyattsville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec 9, 1967	23c. NAME OF CEMETERY OR CREMATORY Oakmont Cemetery	23d. LOCATION (City or Town) (County) (State) Mt Morence Penna
24. FUNERAL DIRECTOR F. Gasch & Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR DEC 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

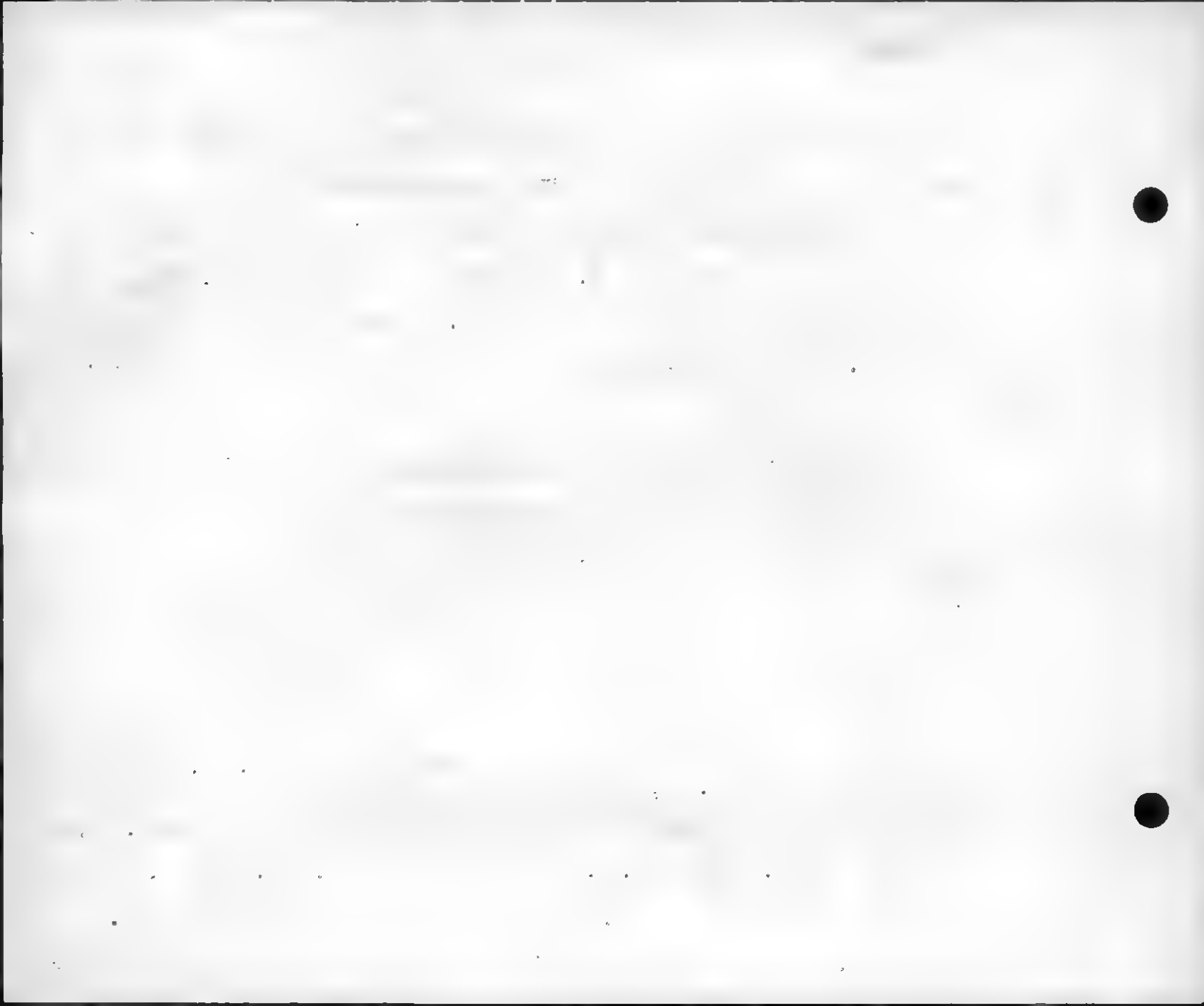


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 15 18 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital					2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park d. STREET ADDRESS 9738 52nd Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Willis E. Taylor					4. DATE OF DEATH Month Day Year Dec. 27, 1967				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 18, 1908		9. AGE (In years lost birthday) 59 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Past Gen. Chairman		10b. KIND OF BUSINESS OR INDUSTRY Ry. Steamship Clerks		11. BIRTHPLACE (County & State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Edward Taylor					14. MOTHER'S MAIDEN NAME May Martin				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. -		17. INFORMANT Mrs. Bond F. Ellison - Dr., New Carrollton, Md. Address 6103-Westbrook			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute generalized Peritonitis 578X DUE TO leakage about sutured bowel segment. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia, bilateral DUE TO (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS A Topsy PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from December 9, 1967 , to Dec. 27, 1967 , that (I) (we) last saw the deceased alive on Dec. 27, 1967 , and that death occurred at 10:46 PM from causes and on the date stated above									
22a. SIGNATURE Don B. Cameron M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Dec. 28, 1967		
22c. PHYSICIAN'S NAME (Type) Don B. Cameron, M.D.					22d. ADDRESS 3503 Perry St., Mt. Rainier, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/2/1968		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery			23d. LOCATION (City or town) (County) (State) Colmar Manor, Md.		
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.					ADDRESS Mt. Rainier, Maryland		25a. REC'D BY REGISTRAR DATE JAN 8 1968		25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17609

1 PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. LENGTH OF STAY IN It <u>66 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hyattsville Nursing Home</u>		d. STREET ADDRESS <u>4305-12th St. N.E.</u>	
3 NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>C.</u> Last <u>Thomas</u>		4 DATE OF DEATH Month <u>12</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/1/1883</u>
9. AGE (In years last birthday) <u>84</u> yrs		10. IF UNDER 1 YEAR Months <u>12</u> Days <u>24</u> Hours <u>19</u> Min <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Washington D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Andrew Wilcox</u>		14 MOTHER'S MAIDEN NAME <u>Mary Mullikin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>577-10-7490</u>	
17 INFORMANT <u>D/ Miss Sugie Wilcox-See Item No. 2</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypertensive pneumonia</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Coronary arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 1/2 yrs.</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 45</u> , to <u>Dec 24, 1967</u> , that (I) (we) last saw the deceased alive on <u>Dec 23, 1967</u> , and that death occurred at <u>6:30 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Richard F. Shaw</u> M.D.		22b. DATE SIGNED <u>12-24-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR RICHARD F. SHAW</u>		22d. ADDRESS <u>1324 Wash. Ave. SE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-27-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>
24 FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>Wash. D.C.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JAN 3 1968</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1-6-67

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS General Delivery	
3. NAME OF DECEASED (Type or print) Kelly		4. DATE OF DEATH 12 17 19 67	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 Feb. 1947
9. AGE (In years last birthday) 20 yrs.		10. IF UNDER 1 YEAR Months 1 Days 17 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Helper		10b. KIND OF BUSINESS OR INDUSTRY N.C.	
11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Solmon Troy		14. MOTHER'S MAIDEN NAME Daniels	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes give war or dates of service)	
17. INFORMANT Solmon Troy		Address Box 113 Upper Marlboro	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Perforating gunshot wound of chest and abdomen Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SHOOTING DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot during altercation	
20c. TIME OF INJURY Month, Day, Year 3:33pm 12-17-67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Old Buck Inn		20f. (City or town) (County) (State) Upper Marlboro, Prince Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		22. DATE SIGNED 12-18-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address (Street, city, town, or county) Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-23-67	
23c. NAME OF CEMETERY OR CREMATORY Barnes Cemetery		23d. LOCATION (City, town or county) (State) North Carolina	
24. FUNERAL DIRECTOR Wm. Keen		25a. REC'D BY REGISTRAR DEC 27 1967	
25b. REGISTRAR'S SIGNATURE Wm. Keen		25c. ADDRESS 4339 Hunt Pl., N.W. Washington, D.C.	

wood

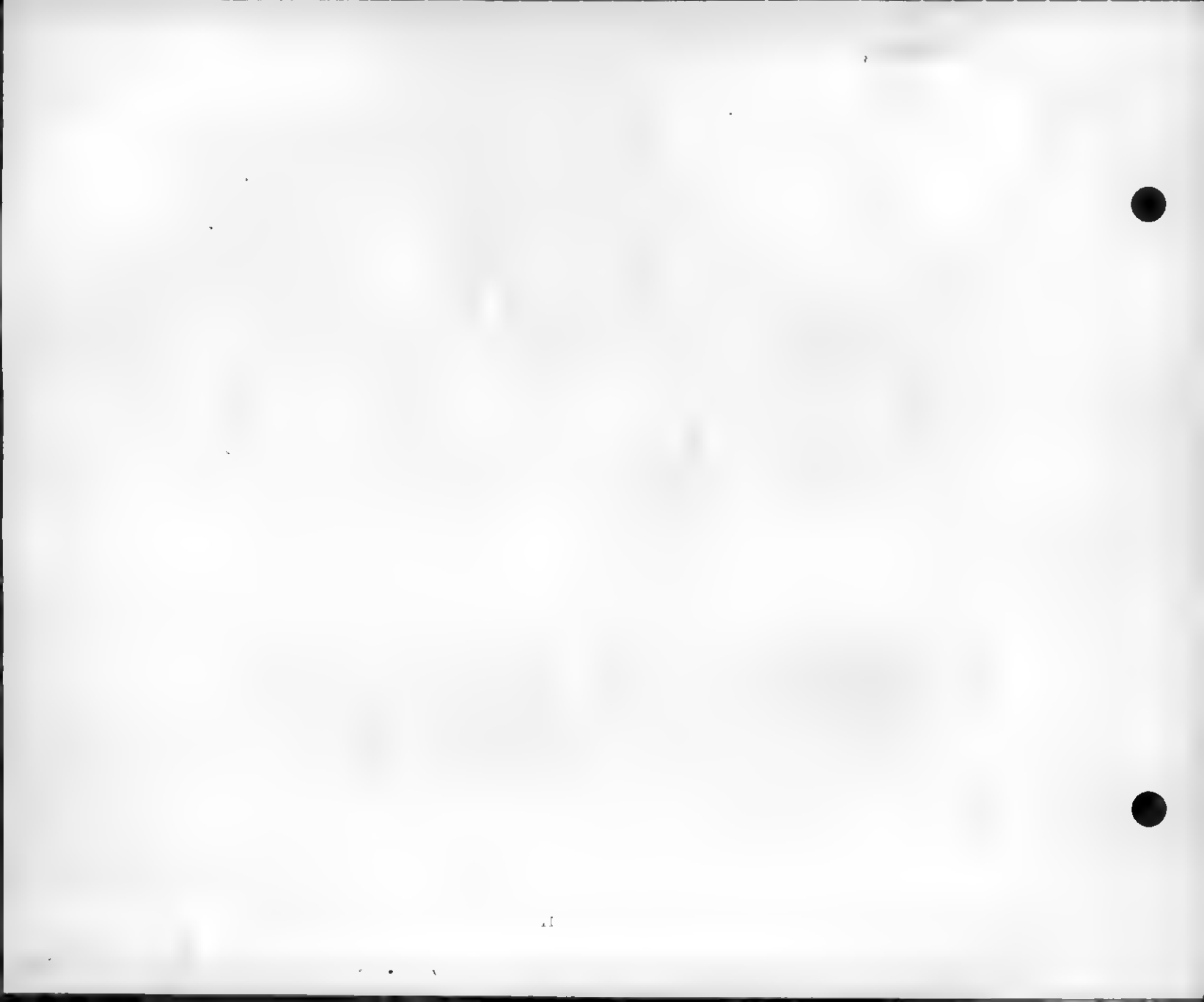
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Pr. Geo. Co. Forestville MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MD b COUNTY 1	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maryland		c LENGTH OF STAY IN 1b Washington, D.C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Regent Nursing Home		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Ester Middle F Last Turner		4 DATE OF DEATH Month Dec. Day 1 Year 1967	
5 SEX Female	6. COLOR OR RACE Colored	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10/30/89
9 AGE (In years lost birthday) 78 yrs.		IF UNDER 1 YEAR Months 78 Days 78 Hours 78 Min 78	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME William Makall		14. MOTHER'S MAIDEN NAME Mary C. Johnson	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17 INFORMANT Alice Leftwich		Address 772 Kenilworth Terrace	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Generalized Arteriosclerosis DUE TO (c) Diabetes Mellitus		INTERVA. BETWEEN ONSET AND DEATH 6 Mo. 10 yrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		9 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour 19 a.m. 19 p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from Aug 4, 1967 , to Dec. 1, 1967 , that (H) (we) last saw the deceased alive on Dec. 1, 1967 , and that death occurred at 8:55 p.m. from causes and on the date stated above			
22a. SIGNATURE W.B. Sheer		22b DATE SIGNED Dec. 1, 1967	
22c PHYSICIAN'S NAME (Type) WALTER B. SHEER MD.		22d ADDRESS 6400 Marlboro Pike S.E. WASH. D.C.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/5/67	
23c NAME OF CEMETERY OR CREMATORY Lincoln Memorial		23d. LOCATION (City or Town) (County) (State) Maryland	
24. FUNERAL DIRECTOR Stewart Funeral Home-4001 Benning RD.		25a REC'D BY REGISTRAR DEC 4 1967	
25b REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

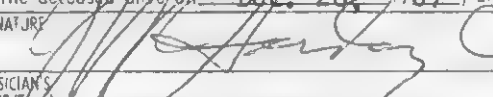

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17608

17612

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 4 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seabrook d. STREET ADDRESS 6920 100th Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Melitta T. Turner		4. DATE OF DEATH Month Day Year Dec. 28, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 22, 1885
9. AGE (In years last birthday) 82 yrs.		10. UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Gustan Tafel		14. MOTHER'S MAIDEN NAME Maria Therese Dorn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 182 36 6841	
17. INFORMANT Mrs. Norman C. Schaller		18. ADDRESS 9220 100th Ave. Seabrook, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Severe stenosing coronary-arteriosclerosis. 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Arteriosclerotic Heart disease. DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (the hospital) attended the deceased from Dec. 24, 1967 , to Dec. 28, 1967 , that (1) (the) saw the deceased alive on Dec. 28, 1967 , and that death occurred at 8:45 M. from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED Dec 29, 1967	
22c. PHYSICIAN'S NAME (Type) James Harding, M.D.		22d. ADDRESS 7601 Riverdale Road, Lanham, Maryland	
23a. BURIAL CREMATION, Cremation	23b. DATE THEREOF 12/29/67	23c. NAME OF TEMPORARY CREMATORY Ft. Lincoln	23d. LOCATION (City or Town) (County) (State) Colmar Manor P. G. Md.
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE JAN 3 1968	25b. REGISTRAR'S SIGNATURE 



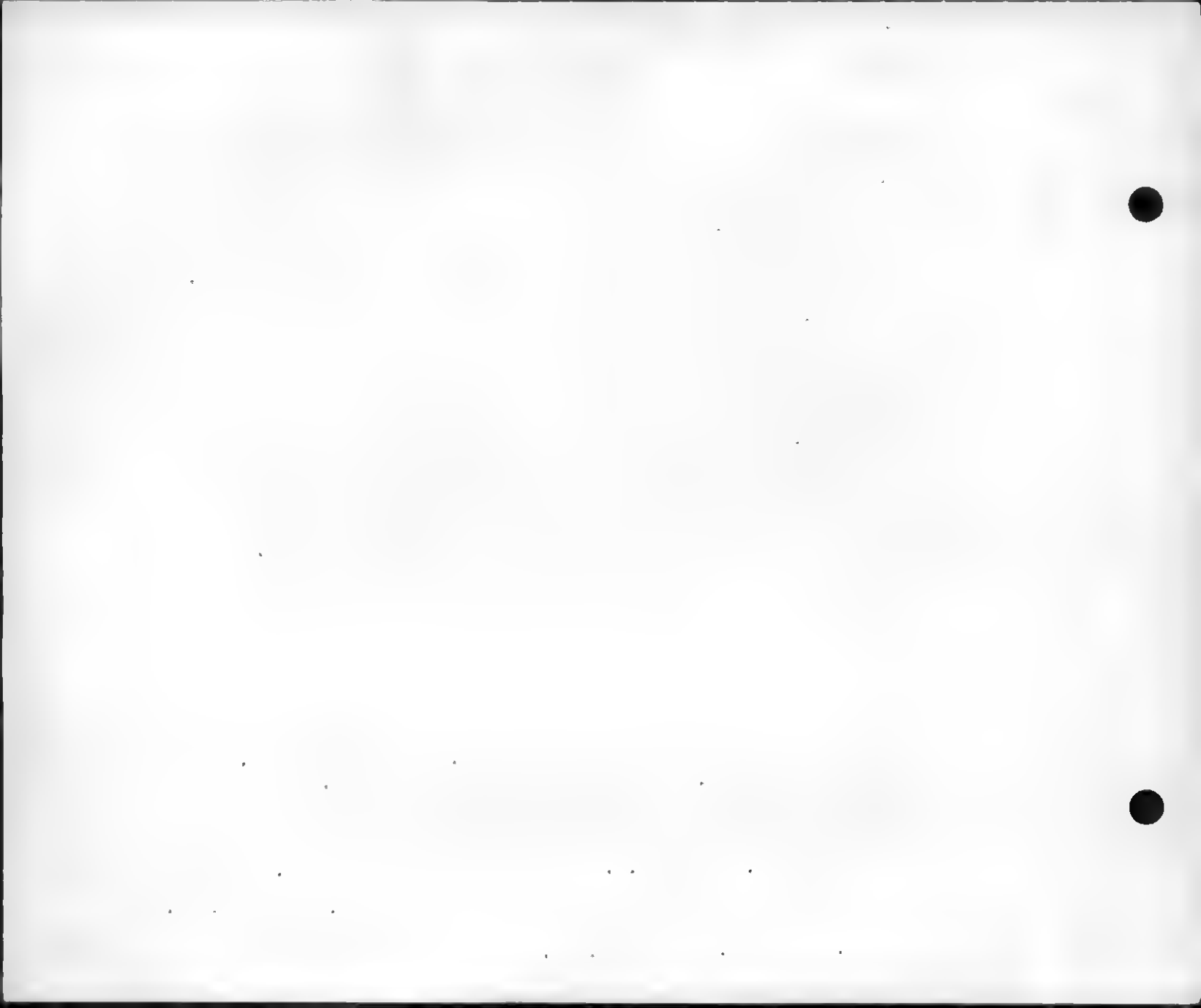
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #11 & 12 Film #1125 12/21/67 ph

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 5 minutes		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS 1523 Ray Road		
3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy Vaughan			4. DATE OF DEATH Month Day Year Dec. 7, 1967		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 7, 1967		9. AGE (In years lost birthday) yrs 5
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Cheverly, D.C. Co.	
13. FATHER'S NAME Danny Hays Vaughan			14. MOTHER'S MAIDEN NAME Dolly Beledso		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 7625 Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Immaturity 700 Gms. (c) Pulmonary Atelectasis, bilateral					INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (the hospital) attended the deceased from Dec. 7, 1967 , to Dec. 7, 1967 , that (I) (we) saw the deceased alive on Dec. 7, 1967 , and that death occurred at 4 A. M, from causes and on the date stated above.					
22a. SIGNATURE James E. Abell			22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) James E. Abell, M.D.
22d. ADDRESS 6001 Landover Rd., Cheverly, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 12-16-67		23c. NAME OF CEMETERY OR CREMATORY Prince George's General Hosp. Cheverly, Md.	
23d. LOCATION (City or Town) (County) (State)					
24. FUNERAL DIRECTOR HARRY W. PENN, JR., Cheverly, Md.		25a. REC'D BY REGISTRAR DATE DEC 21 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



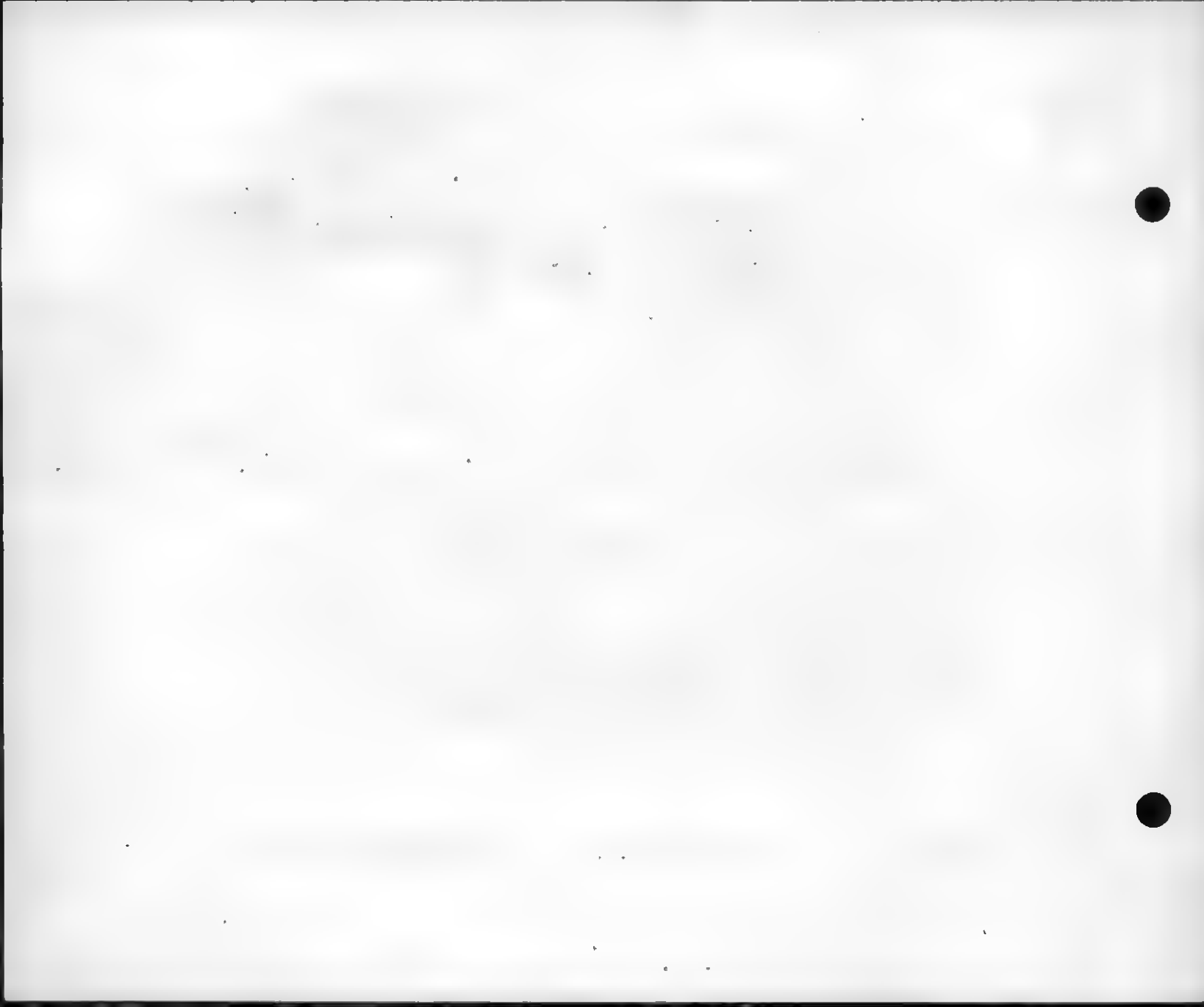
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17614

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 29 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS (MONTGOMERY AVE.) 5200 1/2 Montg Ave. Washington, D.C. 3223 Toledo Place	
3 NAME OF DECEASED (Type of print) First Mildred Last Moss Middle Wageley		4. DATE OF DEATH Month December Day 2 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/25/80
9 AGE (In years last birthday) 87 yrs		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS Hours _____ Min _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Moss		14. MOTHER'S MAIDEN NAME Nancy Beverage	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Nancy Garrett		Address 3223 Toledo Place W. Hyattsville, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Branchio-ectatic DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cardiogenic DUE TO Heart Disease (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour _____ a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/25 , 19 67 , to December 2 , 19 67 , that (I) (we) last saw the deceased alive on 12/1 , 19 67 , and that death occurred at 9:05 AM , from causes and on the date stated above			
22a. SIGNATURE <i>Aaron Deitz</i>		22b. DATE SIGNED 12/2/67	
22c. PHYSICIAN'S NAME (Type) Aaron Deitz, M.D.		22d. ADDRESS Prince George's Plaza, Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 12/5/67	23c. NAME OF CEMETERY OR CREMATORY Grand Prairie	23d. LOCATION (City or Town) (County) (State) Auxvasse, Missouri
24. FUNERAL DIRECTOR The S. H. Hines Co. Washington, D. C.		25a. REC'D BY REGISTRAR DATE DEC 6 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

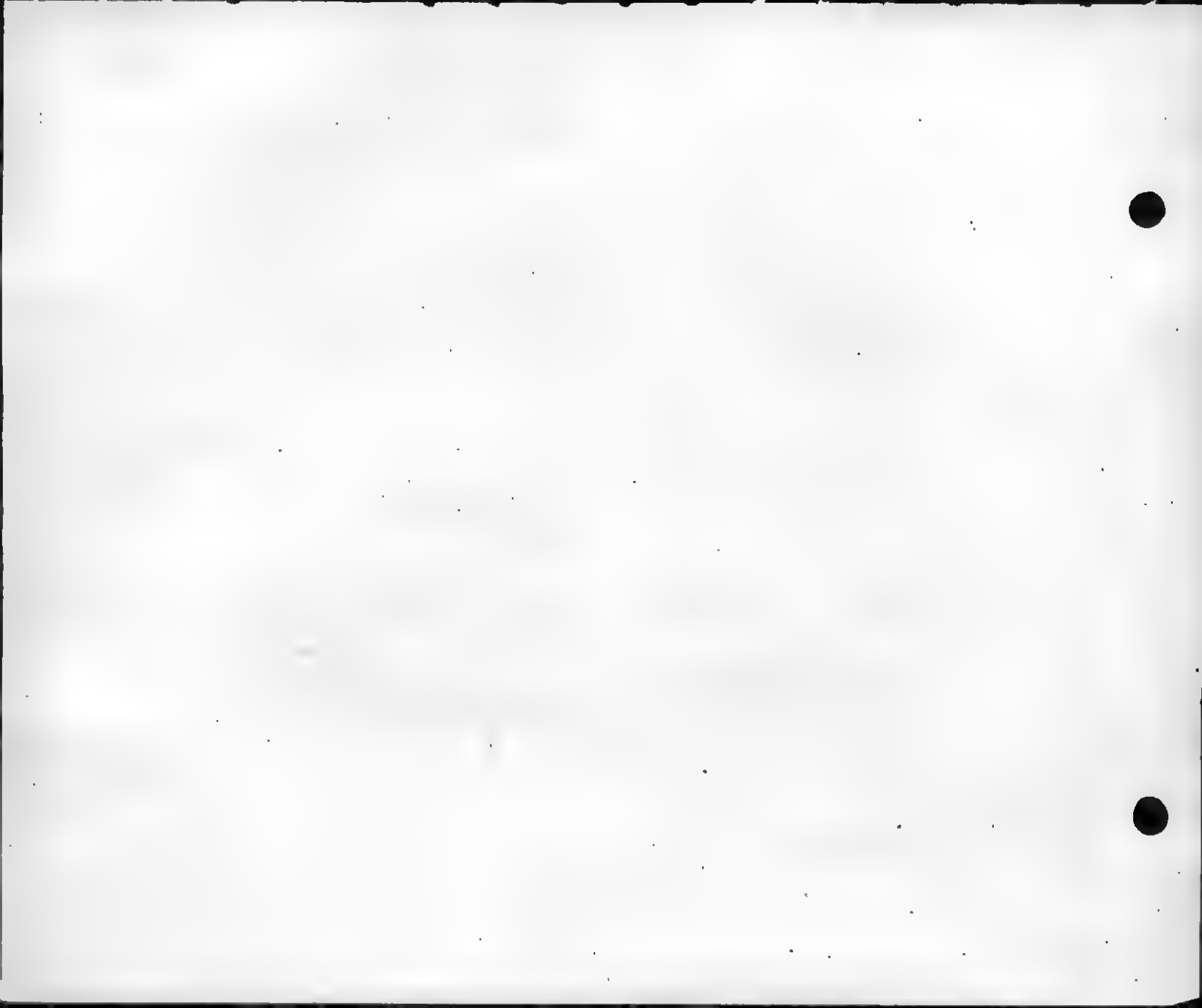
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
Item 4 Film G396 1/12/68 kk											
CERTIFICATE OF DEATH											
1.615											
1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LANHAM c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MAGNOLIA GARDENS NURSING HOME						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BERWYN HEIGHTS d. STREET ADDRESS 5926 NATASHA DRIVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) GORA LEE WALLACE First Middle Last						4. DATE OF DEATH December 29 1967 Month Day Year					
5. SEX FEMALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB 15, 1885		9. AGE (in years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) VIRGINIA			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME DAVID BENNETT						14. MOTHER'S MAIDEN NAME LUCE ROYER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. 577240866A		17. INFORMANT LOUISE W. LUCAS Address 10504 PARKWOOD DR KENSINGTON, MD					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of breast 17-8 DUE TO (b) Heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
INTERVAL BETWEEN ONSET AND DEATH 3 months											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 1967 to Dec 29, 1967 , that (I) (we) last saw the deceased alive on Dec 29 1967 , and that death occurred at 525 PM , from the causes and on the date stated above.											
22a. SIGNATURE Leon Levitsky						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) LEON LEVITSKY						22d. ADDRESS MT. RAINIER, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 1-2-68		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEM		23d. LOCATION (City, town or county) (State) POLMAR MANOR, MD			
24. FUNERAL DIRECTOR W.W. Chambers Co						25a. REC'D BY REGISTRAR 2 JAN 2 1968					
25b. REGISTRAR'S SIGNATURE W.W. Chambers											



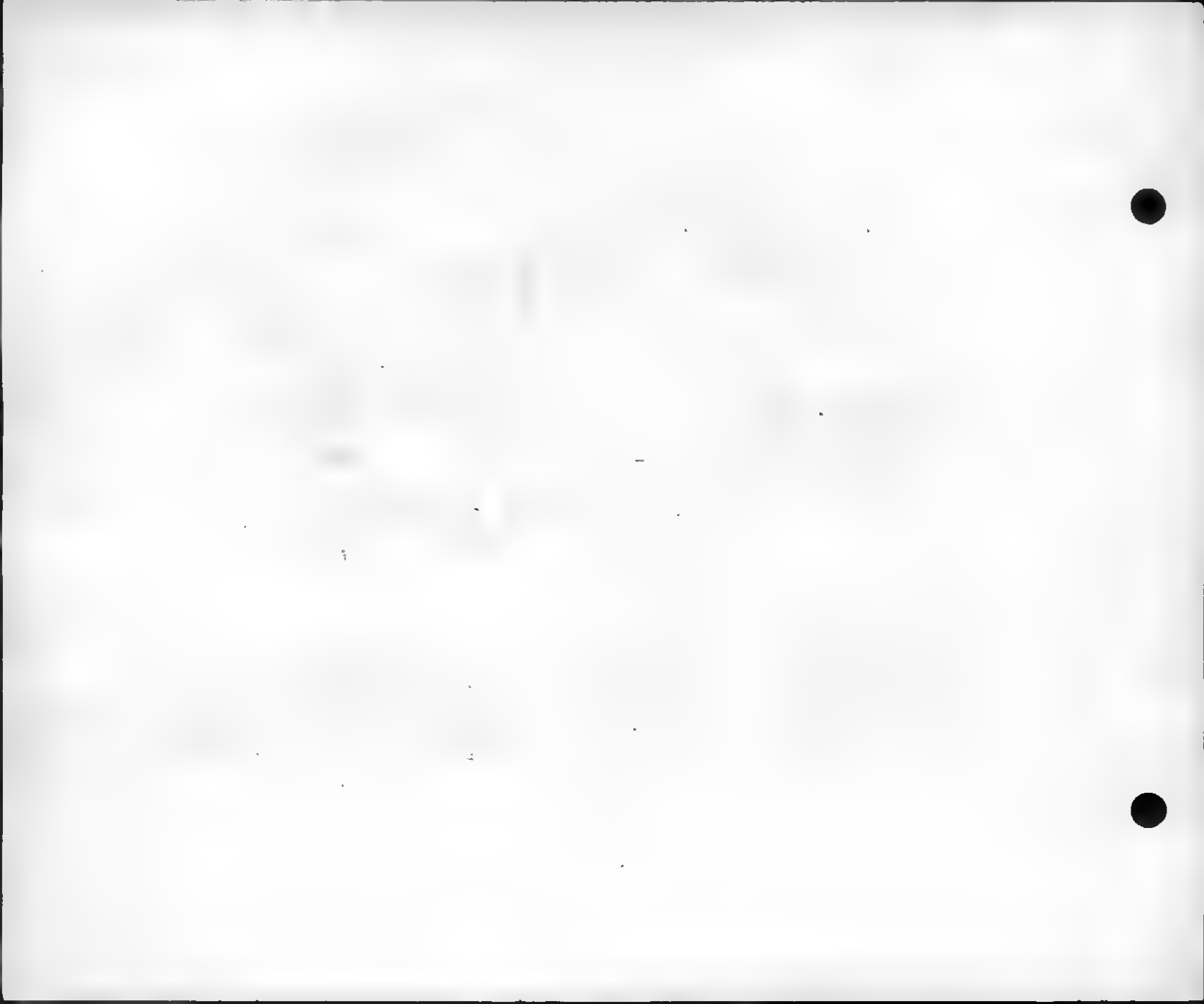
1
8
11612
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11616

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AFB		c. LENGTH OF STAY IN 1b 2 hrs 10min	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MALCOLM GROW USAF HOSPITAL		d. STREET ADDRESS Box 3433	
3 NAME OF DECEASED (Type or print) First JEREMIAH Middle RAYMOND Last WALLACE		4 DATE OF DEATH Month DECEMBER Day 15 Year 1967	
5 SEX MALE	6 COLOR OR RACE NEGRO	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 45 23 Mar
9 AGE (In years last birthday) 22 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) Aquaso, Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME JEREMIAH J. WALLACE		14 MOTHER'S MAIDEN NAME VIRGINIA LEE DOUGLAS	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 215-44-7450	
17 INFORMANT Father		Address Same as item #2	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial hemorrhage DUE TO (b) Massive contusion of brain DUE TO (c) Trauma			INTERVAL BETWEEN ONSET AND DEATH 2 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) Involved in collision with other vehicle	
20c. TIME OF INJURY Month, Day, Year 1215 Dec 15 1967		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Street		20f. (City or town) (County) (State) Prince Georges Md	
21. I certify that (I) (this hospital) attended the deceased from 12:10pm , 19 67 to 3:40 PM 19 67 that (I) (we) last saw the deceased alive on 15 Dec 19 67 , and that death occurred at 3:40PM causes and on the date stated above.			
22a. SIGNATURE Latimer H. Booth		22b. DATE SIGNED 15 Dec 67	
22c. PHYSICIAN'S NAME (Type) LATIMER H. BOOTH, LTCOL		22d. ADDRESS MALCOLM GROW USAF HOSP ANDREWS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/20/67	23c. NAME OF CEMETERY OR CREMATORY John Wesley Church Cemetery Aquasco Rd. Md	
23d. LOCATION (City or Town) (County) (State) Aquasco Md		23e. REC'D BY REGISTRAR DEC 26 1967	
24. FUNERAL DIRECTOR Martell Adams		25b. REGISTRAR'S SIGNATURE [Signature]	



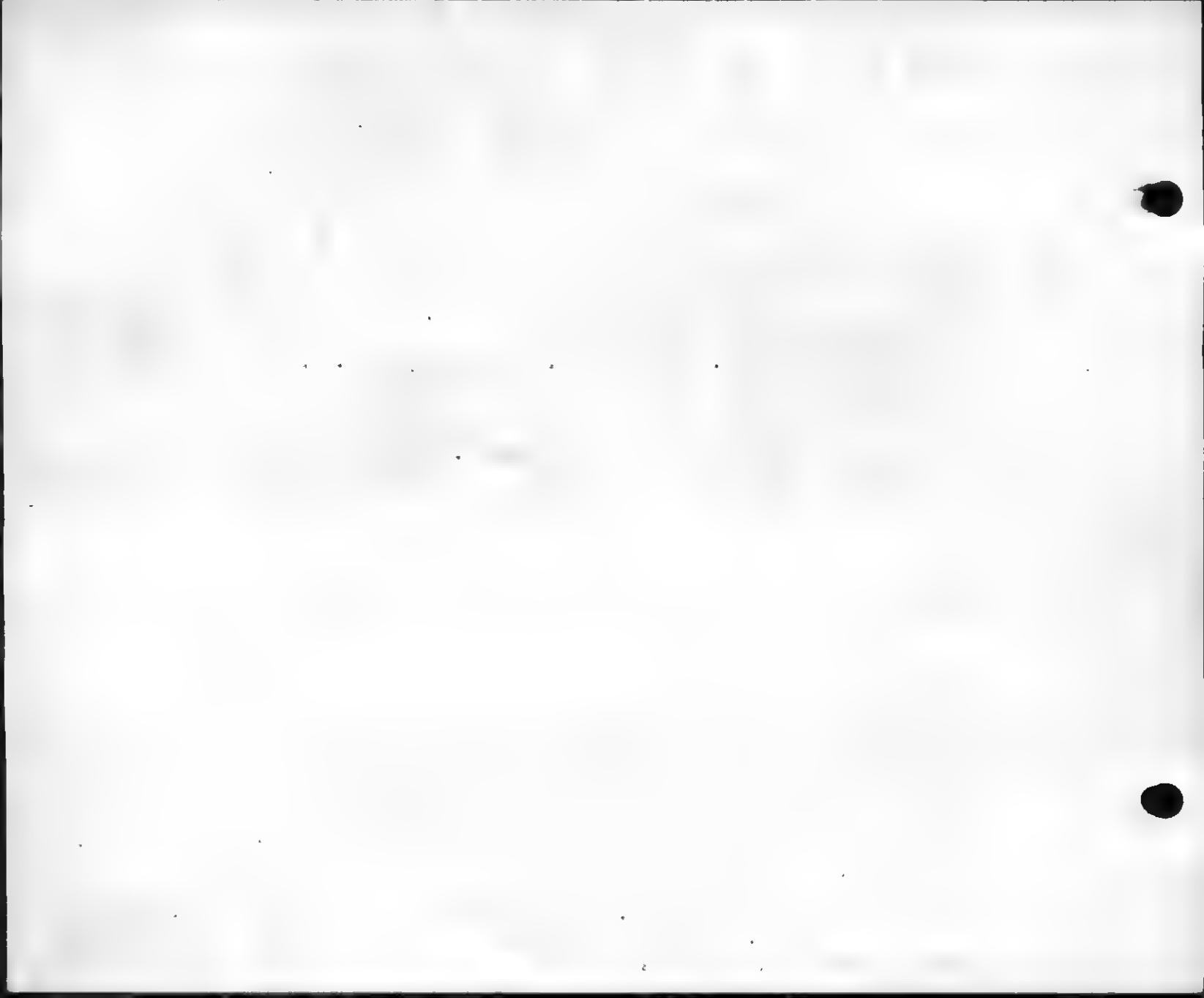
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <u>Prince George</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dear Park Heights</u> <u>16</u> d. STREET ADDRESS <u>4515 Temple Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>Steven Aloysius Walsh</u>			4. DATE OF DEATH Month <u>12</u> Day <u>31</u> Year <u>1967</u>		5. SEX <u>M</u> <u>W</u>			6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Employee Wash. Gas Light Co.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Washington D. C.</u>		9. AGE (In years, last birthday) <u>80</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William Walsh</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mary R. Walsh</u>			Address <u>Same As # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4200</u>										INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>John Kehoe</u>			EXAMINER'S NAME (Type) <u>John Kehoe, M.D., Riverdale</u>			22. DATE SIGNED <u>12-31-67</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>1/3/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges, Maryland</u>				
24. FUNERAL DIRECTOR <u>Robert E. Wilhelm</u> <u>4308 Suitland Road, Suitland, Maryland</u>						25a. REC'D BY REGISTRAR <u>JAN 8 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

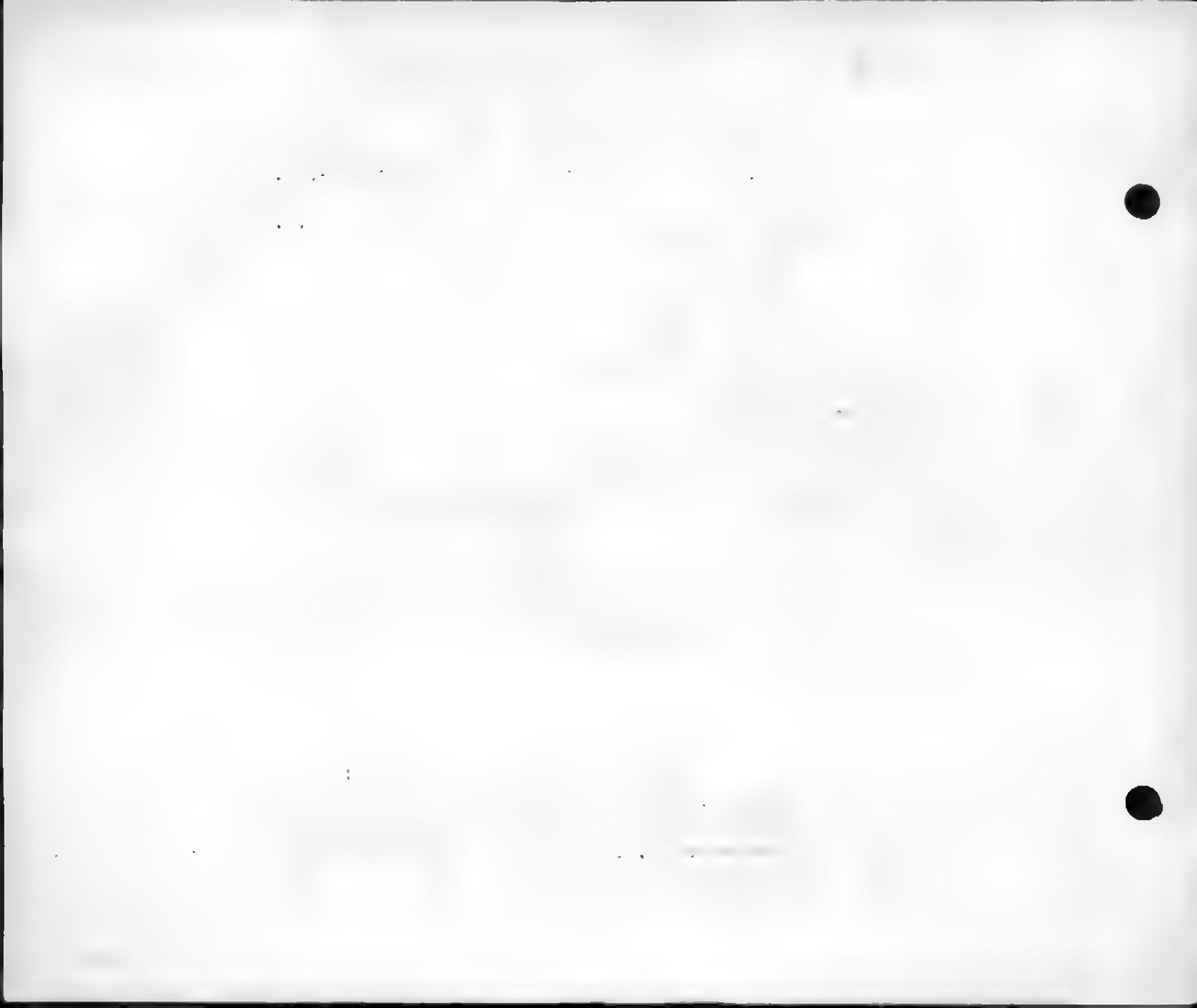
VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17618

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 19 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital				d. STREET ADDRESS 710 8th St., N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Dencie A. Warren				4 DATE OF DEATH Month Day Year 12 / 27 / 19 67			
5 SEX M	6. COLOR OR RACE N	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/10/99		9. AGE (In years last birthday) yrs 68	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Eddie Warren				14. MOTHER'S MAIDEN NAME Sarah Henson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT decedent Address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis, far advanced DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (b) Generalized arteriosclerosis with arteriosclerotic cardiovascular disease and focal encephalomalacia						INTERVAL BETWEEN ONSET AND DEATH 1 mo.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12/8/ 19 67 , to 12/27/67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12/27/19 67 , and that death occurred at 3:10AM from causes and on the date stated above.							
22a. SIGNATURE <i>Moe Weiss</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/27/67	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.				22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-30-67		23c. NAME OF CEMETERY OR CREMATORY Church Cemetery		23d. LOCATION (City or Town) (County) (State) Groesville Md.	
24. FUNERAL DIRECTOR <i>Johnson & Jenkins</i>				ADDRESS 4804 So. Ave. N.W.		25a. REC'D BY REGISTRAR JAN 8 1968	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

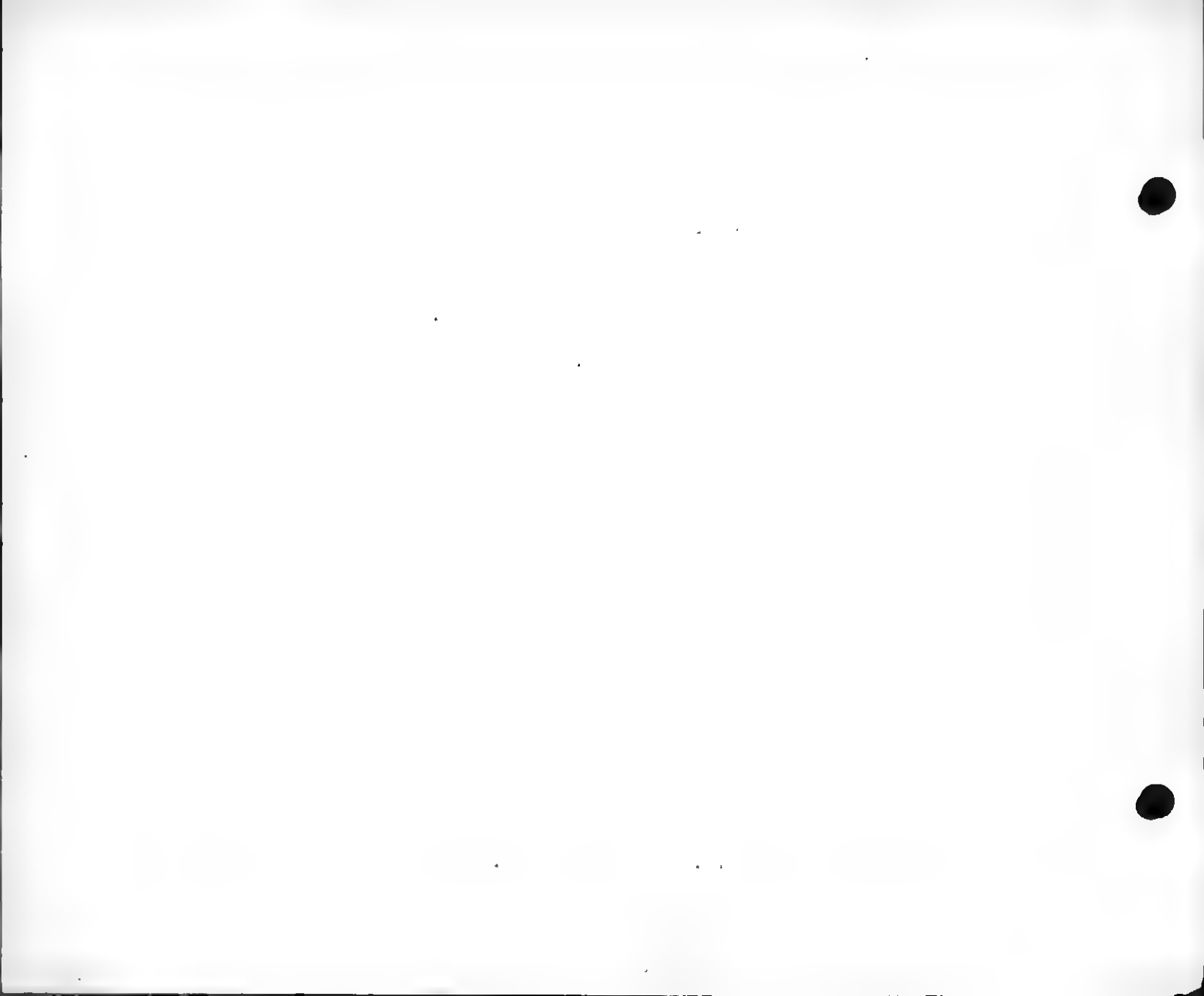
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Robert Washington		4 DATE OF DEATH 12 6 19 67	
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 17 Feb. 1903
9 AGE (In years last birthday) 64 yrs		10 UNDER 1 YEAR Months Days	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14 MOTHER'S MAIDEN NAME Unknown	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16 SOCIAL SECURITY NO 577 24 5442	
17 INFORMANT Mary Ann Washington		Address Clinton, Md. 689 Badger Ave.	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month Day Year 19 Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D. M.D.		22. DATE SIGNED 12-7-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city, town, or county)	
23a. BURIAL, CREMATION, Buried		23b. DATE THEREOF 12/12/67	
23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial		23d. LOCATION (City or Town) (County) (State) Highland Park, Md.	
24 FUNERAL DIRECTOR ROBERT G. MASON FUNERAL HOME, INC. ADDRESS 2500 NICHOLS AVENUE, S.E.		25a. REC'D BY REGISTRAR DEC 14 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

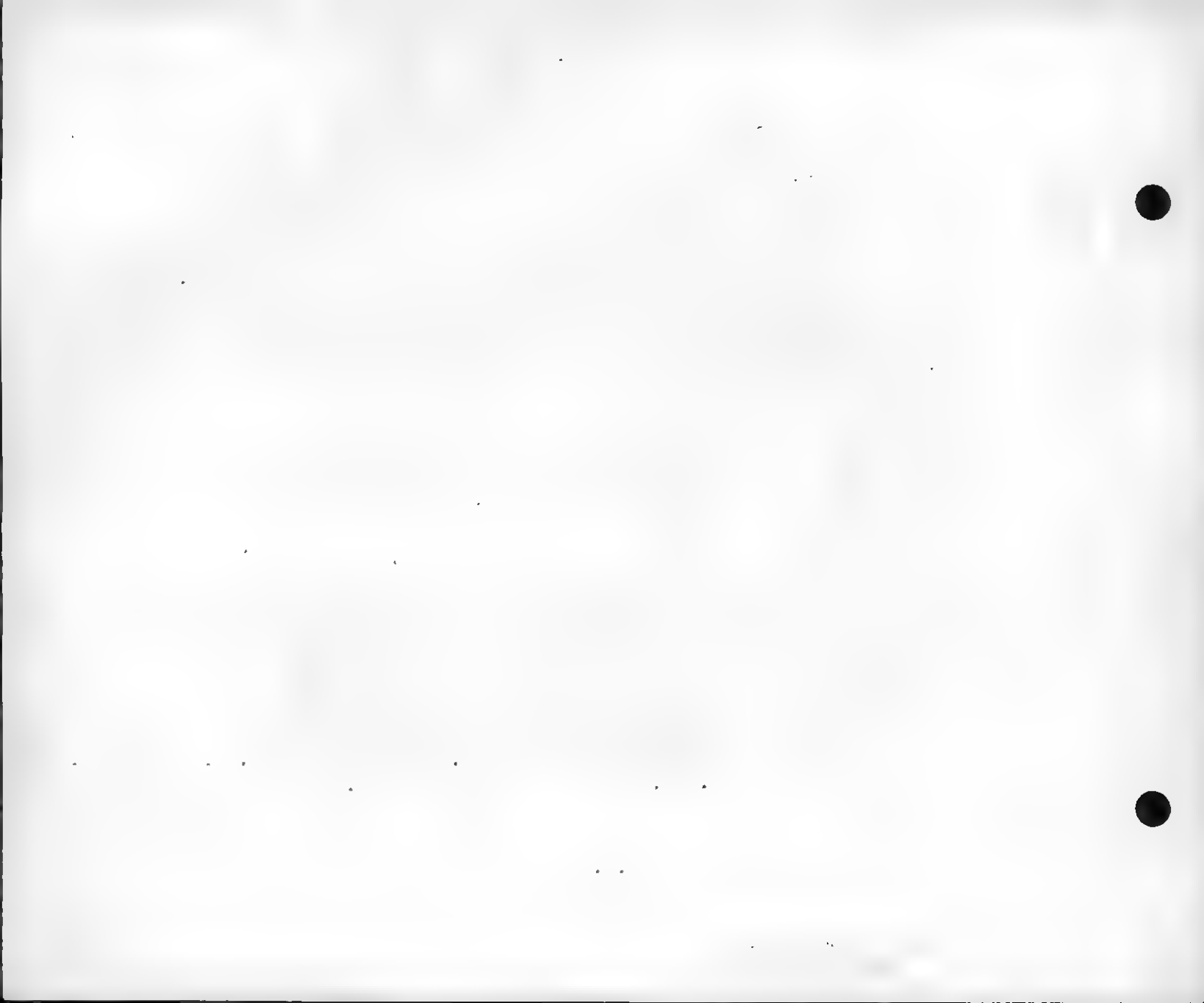
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 23a b c d Film G397 1/24/68 kk
Item 9 Film G397 1/26/68 kk

CERTIFICATE OF DEATH

1621

1. PLACE OF DEATH a. COUNTY Prince georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN It 4 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PrinceGeorges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Ann Marie White				4. DATE OF DEATH Month Day Year Dec 24 19 67			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 May 1925	9. AGE (in years last birthday) 42 yrs	10. UNDER 1 YEAR Months Days Hours Min.		11. UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME unknown			14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address Joan Proctor 326 G St.,		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure; DUE TO secondary to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) severe pulmonary fibrosis (Tuberculosis) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 4 days 1 yr +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from Dec. 21, 1967 , to Dec. 24, 1967 , that (b) (we) last saw the deceased alive on Dec. 24, 1967 , and that death occurred at 7.00AM from causes and on the date stated above.							
22a. SIGNATURE Till Bergemann				M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Till Bergemann, M.D.				22d. ADDRESS Prince Georges General Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/29/1967		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park		23d. LOCATION (City or Town) (County) (State) Landover Md.	
24. FUNERAL DIRECTOR ROBERT V. MASON FUNERAL HOME, INC. 2600 NICHOLS AVENUE, N.E.				ADDRESS MASON 602 - FUNERAL HOME		25a. REC'D BY REGISTRAR DATE IAN 2 1968	
				25b. REGISTRAR'S SIGNATURE we			



THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in to the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17627

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pr. Geo. Gen. Hosp.		d. STREET ADDRESS 6108 62nd Pl.	
3. NAME OF DECEASED (Type or print) HAZEL K. WILLHOIT		4. DATE OF DEATH Month DEC. Day 29 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/10/87
9. AGE (in years last birthday) 80 yrs		10. F UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		12. KIND OF BUSINESS OR INDUSTRY Internal Revenue	
13. BIRTHPLACE (County & State, or foreign country) Nebraska		14. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. FATHER'S NAME Augustus L. Willhoit		16. MOTHER'S MAIDEN NAME Nellie A. Snow	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		18. SOCIAL SECURITY NO	
19. INFORMANT John McQueeney		Address Same as #2	
20. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Circumstances DUE TO (b) Carcinoma of Breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 24 , 19 67 , to 12-29 , 19 67 , that (i) was last saw the deceased alive on 12-29 , 19 67 , and that death occurred at 3:00 PM , from causes and on the date stated above.			
22a. SIGNATURE A. Deitz		22b. DATE SIGNED 12-30-67	
22c. PHYSICIAN'S NAME (Type) Aaron Deitz, M.D.		22d. ADDRESS Prince George's Plaza, Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/2/68	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.	
24. FUNERAL DIRECTOR Francis Gasch's Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR DATE JAN 4 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17618

17623

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON			c. LENGTH OF STAY IN TB D.O.A.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CLINTON COMMUNITY HOSP.				d. STREET ADDRESS 7003 ROCKWELL DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELWOOD Middle WILLIAMS Last WILLIAMS				4. DATE OF DEATH Month DEC Day 14 Year 1967			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/25/1909	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months < Days < Hours < Min <		IF UNDER 24 HRS. Hours < Min <
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MANAGER DRY CLEANERS			10b. KIND OF BUSINESS OR INDUSTRY INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME ALBERT WILLIAMS				14. MOTHER'S MAIDEN NAME MARY BALDWIN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES			16. SOCIAL SECURITY NO. 4201		17. INFORMANT RUBY A. WILLIAMS Address SAME AS # 2		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CONGESTIVE HEART FAILURE 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MASSIVE MYOCARDIAL INFARCTION DUE TO (c) ARTERIOSCLEROTIC CV DISEASE						INTERVAL BETWEEN ONSET AND DEATH 10 MIN. 20 MIN. 3 YRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HEALED MYOCARDIAL INFARCTION						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None				
20c. TIME OF INJURY Month, Day, Year None			20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State) None
21. I certify that (I) (this hospital) attended the deceased from NOV. 1965 to Present , that (I) (we) last saw the deceased alive on NOV 28 1967 , and that death occurred at 3:30 PM , from causes and on the date stated above.							
22a. SIGNATURE Arthur Shaver Jr. M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/14/67	
22c. PHYSICIAN'S NAME (Type) ARTHUR SHAVER JR				22d. ADDRESS 6808 BRANCH AVE. CLINTON			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/18/67		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY		23d. LOCATION (City or Town) (County) (State) ARLINGTON VIRGINIA	
24. FUNERAL DIRECTOR ROBERT E. WILHELM ADDRESS 4308 SUTLAND ROAD, SUTLAND, MARYLAND				25a. REC'D BY REGISTRAR DEC 19 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 24 hours after death.

1 - Certificate signed with permission of Dr. Kaboe

1987

21357

THE MARCH

1987

0.5 0.7 1.0

1.0 1.5 2.0

2.5 3.0 3.5

4.0 4.5 5.0

5.5 6.0 6.5

7.0 7.5 8.0

8.5 9.0 9.5

10.0 10.5 11.0

11.5 12.0 12.5

13.0 13.5 14.0

14.5 15.0 15.5

16.0 16.5 17.0

17.5 18.0 18.5

19.0 19.5 20.0

20.5 21.0 21.5

22.0 22.5 23.0

23.5 24.0 24.5

25.0 25.5 26.0

26.5 27.0 27.5

28.0 28.5 29.0

29.5 30.0 30.5

31.0 31.5 32.0

32.5 33.0 33.5

34.0 34.5 35.0

35.5 36.0 36.5

37.0 37.5 38.0

38.5 39.0 39.5

40.0 40.5 41.0

41.5 42.0 42.5

43.0 43.5 44.0

44.5 45.0 45.5

46.0 46.5 47.0

47.5 48.0 48.5

49.0 49.5 50.0

50.5 51.0 51.5

52.0 52.5 53.0

53.5 54.0 54.5

55.0 55.5 56.0

56.5 57.0 57.5

58.0 58.5 59.0

59.5 60.0 60.5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
Item 1d Film G396 1/5/68 kk CERTIFICATE OF DEATH 17624											
1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PR GEO</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BRANDYWINE</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BRANDYWINE</u> 16.1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rt. 1 Box 316</u>						d. STREET ADDRESS <u>RT. 1 Box 316</u>					
3. NAME OF DECEASED (Type or print) First <u>Roy</u> Middle <u>—</u> Last <u>YOUNG</u>						4. DATE OF DEATH Month <u>12</u> Day <u>19</u> Year <u>1967</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 10, 1892</u>		9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING - TOBACCO FARMER</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>BRANDYWINE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BRANDYWINE</u>			
13. FATHER'S NAME <u>DAVID THOS. YOUNG</u>						14. MOTHER'S MAIDEN NAME <u>ANNA WATSON</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES WW I</u>						16. SOCIAL SECURITY NO. <u>577-24-9415</u>		17. INFORMANT <u>NELLIE YOUNG</u> Address <u>RT. 1 Box 316 BRANDYWINE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>1992</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senile calcification</u> (c) <u>—</u>										INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> a.m. <u>—</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from <u>10-12</u> , 19 <u>64</u> , to <u>12-19</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>12-19</u> , 19 <u>67</u> , and that death occurred at <u>10:11</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>[Signature]</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-20-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>RICHARD DOBSON</u>						22d. ADDRESS <u>BRANDYWINE, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-22-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>IMMANUEL</u>		23d. LOCATION (City, town or county) (State) <u>BADEN PR. GEO MD</u>					
24. FUNERAL DIRECTOR <u>HUNTT FUNERAL HOME WILDFORD, MD</u>						25a. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>DEC 28 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



Handwritten text, possibly a signature or date, located in the center of the page.

Handwritten text at the bottom of the page, including what appears to be a signature and some illegible markings.